Waltham Forest Health and Care Partnership Board & Integrated Care Board Sub Committee meeting in common

Monday 03 July 2023, 1130-1330 at Board Room, Junction 6, Whipps Cross Hospital London E11 1NR

Joint Chairs: Heather Flinders & Ralph Coulbeck

AGENDA

	Item	Time	Lead	Attached / verbal	Action required
Waltham Forest Health and Care Partnership Board Business					
1.	**Welcome, introductions and apologies** • Declaration of conflicts of interest • Minutes of the meeting held on 15 May 2023 • Action Log • Matters Arising	1130 (5 mins)	Chairs	*Papers 1a, 1b & 1c* Pages 3-14	Note Approve Note
2.	**Questions from the public**	1135 (5 mins)	Chairs	*Verbal*	Discuss
3.	**Partner updates or escalations – by exception**	1140 (10 mins)	Chairs	*Verbal*	Note
4.	**Homeless Resident Voice - experience of health services in WF** **Homeless Health in Waltham Forest**	1150 (40 mins)	Cheryl Tribe Kelvin Hankins / Dr Claire Rees / Selina Douglas	*Paper 4a* *Pages 15-35*	Discuss
5.	**Community Transformation Highlight and Exception reports** • Performance and Outcomes Framework	1230 (15 mins)	Pat Smith	*Paper 5a* *Pages 36-72*	Discuss

6.	**Update from Quality Subgroup**	1245 (15 mins)	Ken Aswani	*Paper 6a* *Pages 73-81*	Discuss
Waltham Forest Integrated Care Board Sub Committee Business					
7.	**Better Care Fund 2023/25 Plans**	1300 (10 mins)	Anna Saunders	*Papers 7a, 7b & 7c* *Pages 82-133*	Approve
8.	**Month 2, 2023/24 Finance Report** • 2023/24 Operating Plan • Month 2, 2023/24 WF Partnership Budgets (HI. IIF, Transformation programme) • Health Inequality Budget planning 2023-2026	1310 (15 mins)	Sunil Thakker / Anna Saunders	*Papers 8a, 8b, 8c, 8d, 8e & 8f* *Pages 134-170*	Discuss
9.	**Any Other Business**	1325 (5 mins)	Chairs		
Date of next meeting: Monday 07 August 2023, 1130-1330 at May Suite, (East Wing, 1st floor) Waltham Forest Town Hall; Forest Road, Walthamstow, E17 4JF					

- Declared Interests as at 16/06/2023

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Brid Johnson	Member of sub-committee (representative of NELFT)	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board Havering ICB Sub-committee Havering Partnership Board Redbridge ICB Sub-committee Redbridge Partnership Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indirect Interest	Mid and South Essex ICB	My Partner is a Non-Executive Director at MSE ICB	2022-08-25		
Chetan Vyas	Director of Quality	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indirect Interest	North East London CCG	Spouse is an employee of the CCG	2014-04-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Some GP practices across NEL	Family members are registered patients - all practices not known nor are their registration dates	2014-04-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Redbridge Gujarati Welfare Association - registered charity in London Borough of Redbridge	Family member is a Committee member.	2014-04-01		Declarations to be made at the beginning of meetings
Ken Aswani	Waltham Forest Clinical Director	Clinical Advisory Group Waltham Forest Health and Care	Financial Interest	Allum Medical Centre	GP Partner - Allum Medical	1990-01-01		Declarations to be made at the beginning of meetings

		Partnership Board Waltham Forest ICB Sub-committee			Centre			
			Non-Financial Professional Interest	NEL RCGP Faculty	Member	1995-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Fednet	Member Practice	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	CQC	GP Inspector (Not in NE London)	2014-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Clinical Panel	Advisory Role (Not in NE London)	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Mirch Medical	partner is a director of Mirch Medical . Not a provider of any commissioned services in NE London . Works as GP	2019-01-01		No action required as no conflicts declared.
Naheed Khan-Lodhi	PCN Clinical Director	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Financial Interest	Queens Road Medical Centre	Partner In Practice	2000-04-01		
			Financial Interest	Walthamstow West PCN	PCN Clinical Director	2019-07-01		
			Financial Interest	Waltham Forest GP Federation	FedNet Clinical Director and Vice Chair	2022-01-01		
Steve Collins	Executive Director of Finance	Barking & Dagenham Partnership Board ICB Audit and Risk Committee ICB Finance, Performance & Investment Committee Newham Health and Care Partnership Primary care contracts sub-committee Redbridge Partnership Board Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board	Non-Financial Professional Interest	Trisett Limited (business support service)	Director	2003-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Hope Church Sevenoaks	Chair of Trustees	2020-10-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Surgeons (charity) (formerly Fegans)	Wife is a Trustee	2017-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	PwC	Daughter is Manager	2019-01-01		Declarations to be made at the beginning of meetings

Sue Boon	Integrated Care Director	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Financial Interest	Stepping Stones	Board Member	2018-01-01		Declarations to be made at the beginning of meetings
Vanessa Morris	Member of City and Hackney Neighbourhood Health and Care Board	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Financial Interest	Mind in the City, Hackney and Waltham Forest	Employer	2019-12-09		

- Nil Interests Declared as of 16/06/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
Andrea Antoine	Deputy Director of Finance, TNW ICP	Newham Health and Care Partnership Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.
Hakeem Badmus	Planning and Performance Manager	Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.
Dianne Barham	Healthwatch, Tower Hamlets	ICP Committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Ralph Coulbeck	Director of Strategy	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
William Cunningham-Davis	Director of Primary Care Transformation, TNW ICP	Newham Health and Care Partnership Newham ICB Sub-committee Primary care contracts sub-committee Tower Hamlets ICB Sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Heather Flinders	Strategic Director of Families	ICS Executive Committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Kelvin Hankins	Deputy Director of Unplanned Care	Newham Health and Care Partnership Newham ICB Sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Mark Lobban	Director Integrated Commissioning	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Sunil Thakker	Director of Finance; C&H ICP & Acting Director of Finance; TNW ICP	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Redbridge Partnership Board Tower Hamlets ICB Sub-committee	Indicated No Conflicts To Declare.

		Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	
Jennifer Rush	Senior Communications and Engagement Manager	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Matthew Knell	Senior Governance Manager	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Finance, Performance & Investment Committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Janakan Crofton	Care Closer to Home Clinical Lead	Primary Care Collaborative sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Amber Harris	Engagement and Community Communications Manager	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Selina Douglas	Executive Director of Partnerships	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board Havering ICB Sub-committee Havering Partnership Board Mental Health, Learning Disability & Autism Collaborative sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Charlotte Pomery	Chief Participation and Place Officer	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Joe McDonnell	Member of a committee	Clinical Advisory Group Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.

Pat Smith	Member of the WF PbP Health and Care Board	Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.
Alastair Finney	Interim Lead for Integrated Delivery Framework for Waltham Forest, Redbridge and Whipps Cross Hospital (accountable to NEL ICB)	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Darren McAughtrie	Member of a sub committee/ borough based partnership	Mental Health, Learning Disability & Autism Collaborative sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
OLUREMI ODEJINMI	MEDICAL DIRECTOR WHIPPS CROSS UNIVERSITY HOSPITAL	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Philomena Arthur	Member of the Waltham Forest Health and Care Partnership board	Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.
Paul Nana	Partner	Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.
Beatrice Stern	Communications and Stakeholder Manager – Tower Hamlets, Newham and Waltham Forest	Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Naheed Asghar	Committee member	ICP Committee Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.

Minutes of Waltham Forest Health and Care Partnership Board
11:30-1.30pm
Monday 15 May 2023, 1130-1330 at Board Room, Junction 6, Whipps Cross Hospital London E11 1NR

Members:	
Ralph Coulbeck (RC) Joint Chair	Chief Executive, Whipps Cross Hospital, Barts Health NHS Trust
Sue Boon (SB)	Director of Delivery Waltham Forest, North East London NHS Foundation Trust & NHS North East London
Joe McDonnell (JMD)	Director of Public Health, London Borough of Waltham Forest
Ken Aswani (KA)	Clinical Director, NHS North East London
Vanessa Morris (VM)	Chief Executive, City, Hackney & Waltham Forest MIND
Philomena Arthur (PA)	Integrated Care Director Waltham Forest, North East London NHS Foundation Trust
Selina Douglas (SD)	Executive Director of Strategy & Partnerships, North East London NHS Foundation Trust
Pat Smith (PS)	Waltham Forest Programme Director, North East London NHS Foundation Trust
Darren McAughtrie (DM)	Corporate Director Adult Social Care, London Borough of Waltham Forest
Dr Janakan Crofton (JC)	Clinical Lead for Care Closer to Home & Senior Responsible Owner, North East London NHS Foundation Trust
Dianne Barham (DB)	Chief Executive, Waltham Forest Health Watch
Alastair Finney (AF)	Programme Director, Whipps Cross Redevelopment Programme, Barts Health NHS Trust
Sunil Thakker (ST)	Director of Finance, NHS North East London
Daniel Phelps (DP)	Corporate Director for children's social care, London Borough of Waltham Forest
Olurenmi Odejinmi (OO)	Medical Director, Whipps Cross, Barts Health NHS Trust
Dr Asad Ashraf (AA)	PCN Director, Primary Care Network
Attendees:	
Matthew Knell (MK)	Senior Governance Officer, NHS North East London
Shakila Talukdar (ST)	Governance Officer, NHS North East London (notes)
Charlotte Pomery (CP)	Chief Participation and Place Officer, NHS North East London
Anna Saunders (AS)	Assistant Director of Integrated Commissioning, NHS North East London
Katy Briggs (KB)	Head of Integrated Commissioning - Children and Young People
Heather Sayers (HS)	BCYP Transformation Programme Manager, London Borough of Waltham Forest
Lauren Ovenden (LO)	Corporate Director of Education, London Borough of Waltham Forest
Kashif Nawaz (KN)	Assistant Director for SEND (Interim), London Borough of Waltham Forest (joined online - teams)
Tonia Myers (TM)	GP Clinical Lead for Children and Young People, Waltham Forest
Robert Selley (RS)	Strategy Lead, Represented for Alastair Finney, Barts Health NHS Trust
Apologies:	
Heather Flinders (HF) Joint Chair	Strategic Director of People, London Borough of Waltham Forest (Joint Chair)
Chetan Vyas (CV)	Quality Director, NHS North East London

Alastair Finney (AF)	Programme Director, Whipps Cross Redevelopment Programme, Barts Health NHS Trust
Dr Sheraz Younas (SY)	Medical Director, Waltham Forest GP Federation Network
William Cunningham Davis (WCD)	Director of Primary Care, NHS North East London
Kelvin Hankins (KH)	Deputy Director Unplanned Care, NHS North East London
Dr Naheed Khan Lodhi (NLK)	Director, Primary Care Network

Item No.	Item title
1.	**Welcome, Introductions and apologies** The chair welcomed members and attendees to the May 2023 meeting of the Waltham Forest Health and Care Partnership Board (HCPB) and highlighted the apologies as listed above. **1.1 Declarations of Interest** It was confirmed that no declarations of interest were held by members or attendees in the meeting's business. **1.2 Minutes of the meeting held on 03 April 2023** The board approved and agreed the minutes as an accurate reflection of the meeting. **1.3 Action Log** Open actions related to Mental Health Actions: 0603-01, 0603-05 and 0603-08 **ACTION:** Selina Douglas (SD) to provide an update offline. **1.4 Matters Arising – Marmot / Fuller update** No matters arising was discussed. Sue Boon (SB) provided the HCPB board with an update on Fuller/ Locality Hubs and highlighted that: • Vision for hubs socialised with Primary care transformation group. • The locality hub model has been presented to the Local Infrastructure group for support with identifying estates options and IT strategic support. • Pilot funding for Locality hub pathway design has been identified in HI fund. • Locality hub model has influenced the procurement of diagnostic services discussions. Joe McDonnell (JMD) provided the HCPB with an update on Marmot and highlighted that: • Mapping in health against recommendations underway and due to complete by end of May. • Discussions progressed with facilitation partner to determine potential role, incorporating feedback from HCP Board. Partner agreed with proposal to incorporate Fuller response in scope of work • Final proposal due to be brought to Exec in May, ahead of June HCP Board. **ACTION**: Sue Boon (SB) and Joe McDonnell (JMD) to incorporate integrating bring back Marmot / Neighbourhood and Fuller alignment discussions to the June board development session.
2.	**Partner updates or escalations – by exception** There was no updates or escalations noted.
3.	**Babies, children and young people focus** **Update on BCYP strategy development including resident engagement** Daniel Phelps (DP) and Heather Sayers (HS) talked members through the circulated papers and highlighted the following points:

- The Health Care Partnership Board (HCPB) discussed and noted slide 19 is talking directly to children and young people's families, there are lots other groups want to engage. Lots of children spoke about impact on covid, the educational aspirations changed impact on children's mental health.
- Younger children want play opportunities that will benefit their health and wellbeing. Safety conversations came up quite a lot, fitness was really important. Racism also came up a lot especially with black people.

Comments and questions from the HCPB included that:

- There are ten priorities partnerships have, slide 23 shows strategy next steps overview. The overall challenges on Joint Strategic Needs Assessment (JSNA) strategies are complete.

Update on service developments

Daniel Phelps (DP)) talked members through the circulated papers on and highlighted the following points:

- The Health Care Partnership Board (HCPB) discussed and noted the purpose of this paper was to update board transformation to date.
- The key risks are gaps around strategy and develop needs assessment for borough.
- Slide 37 talks about developing strategy, refreshing JSNA and trying to do cross cutting work.
- Slide 38 has four key priorities that focuses on BCYP work at the exec oversight group. The two risks identified are covered in slide 39, these are, children's programme and SEND.

Comments and questions from the HCPB included that:

- To ensure all areas and gaps are covered and to show data on how progress is monitored.
- JMD leads the strategic oversight group for vaccinations for children in Waltham Forest. The work is being progressed in all age groups.
- There is a focus on delivery, important discussions to take forward.
- The HCPB noted outcomes framework is being developed this is also updated on innovations and investments project.
- The HCPB recognised the challenge is to have fewer than ten priorities, and the importance of primary prevention to get families hub as well, the other area is care closer to home, this affects the whole system and needs to be addressed. In terms of root causes that links in with Marmot.
- A question was raised how are we engaging with parents? Early intervention and prevention? Feels like a really broad partnership to deliver these changes culture and families, couldn't see that reflected and a whole set of thinking around risk, it is important to link to providers early intervention services.
- HS will base herself in one of the hubs and have those conversations.
- Another question was raised how do we ensure partnership works around children's needs? To Map that out and focus on what will be done in the BCYP group.
- There is lots of work going around council, suggested to align structure to it and to embed crosscutting themes processes in priorities.
- The HCPB noted that there is a lot of insight in paternity work will be done with key levers and young influencers

SEND inspection framework

Kashif Nawaz (KN) joined the meeting online and talked members through the circulated papers on and highlighted the following points:

- The Health Care Partnership Board (HCPB) discussed and noted the paper indicates new inspection framework and focuses on the green paper. Around 2/3 received a written statement, the timeline is three weeks for a new inspection framework.

	• Inspectors are looking to establish evaluation criteria (slide 45). • The next steps for Waltham Forest are: 1. The proposal is to present a full update on the work that is currently being done to prepare the Local Authority Partnership systems for this upcoming inspection at the BCYP Executive Oversight Group in June. 2. A Self Evaluation Form (SEF) is currently underway and a summary of this will be presented in full at the BCYP Executive Oversight Group. 3. This update will detail how the inspection preparation leads into a cycle of improvement for children and young people with SEND and how we meet the outcomes for young people with SEND within the new framework. Comments and questions from the HCPB included that: • The HCPB recognised there has been SEND thematic view in Barking & Dagenham borough and asked it would be good to see that work. **ACTION:** Daniel Phelps (DP) and Heather Sayers (HS) to incorporate diagram of all BCYP planning structures onto the slide pack. **ACTION:** Daniel Phelps (DP) to take further SEND updates including an action plan to the BCYP Oversight group and exceptions escalated to Board. **ACTION:** Charlotte Pomery (CP) to share B&DHR letter regarding SEND thematic reviews with WF colleagues. **ACTION:** Shakila Talukdar (ST) to add CYP to forward planner to come back for quarterly updates.
4.	**Better Care Fund** Anna Saunders (AS) talked members through the circulated papers and discussed the following points: **2022/23 End of year report** • The HCPB noted and discussed the 2022/23 BCF End of Year first submission which has been agreed and is being submitted 2nd May and that the first draft of the plan is subject to change and reflect the inclusion of data that will be published on the 10 May, to enable completion of the template for final submission. **2023/25 Plan** • The 2023/25 draft BCF plan is due for submission by 19 May but the regional team will accept draft plans up to 9th June. • The deadline for submitting the 2023/25 BCF plan is 28 June. HCPB to delegate sign-off of the draft plan to the Executive Group. Comments and questions from the HCPB included that: • The HCPB recognised that there is a big piece of work being done on the scoping of spend going forward. **ACTION:** Anna Saunders (AS) to delegate BCF sign off of the plan to Exec Group **APPROVAL:** The first draft narrative submission for the BCF 23/24 was circulated for comments and the 22/23 final submission was approved.
5.	**Community Transformation programme** Pat Smith (PS) and Darren McAughtrie (DMA) talked the HCPB members through the circulated papers which provided an update on progress of the Integrated care programme in Waltham Forest, building on the aims and aspirations of the Integrated care programme business case. This includes updates on Home First, Care Closer to Home, Centre of Excellence and update on status of the Digital Hub sub-workstream and information on the future recommissioning options for Bridging and Reablement.

	The HCPB discussed and noted the following points: • Working with System partners around recommissioning as indicated in slides 68 -73 • Current contract with reablement is out of timescale and recommissioned. Home first is integrated with bridging work, this is the preferred method of doing reablement service model going forward. Comments and questions from the HCPB included that: • The HCPB noted that primary care is trying to integrate baseline data with LTC model, looking at diabetes on how to implement tech to reduce appointments will need to re-evaluate and offer something more cost effective. • The HCPB recognised better correlation in the re-admission trend data between discharge hubs/ teams. • The HCPB raised two issues, 1. Virtual appointments for care homes and 2. Dentistry It was noted that a lot of the dentists in the borough won't take NHS patients. **ACTION:** Pat Smith (PS) to add Bed capacity to the performance report. **ACTION:** Sue Boon (SB) to consider where and how to have a WF system discussion re access to Dentistry and for the Board to be informed of the issues. **ACTION:** Shakila Talukdar (ST) to add Dentistry to forward planner
6.	**2022/2023 Finance report** Sunil Thakker (ST) talked the HCPB members through the year end position of the Innovation Funds for 2022-23 and highlighted the following points: • The operating plan was submitted on 4th May 2023 small surplus around £15m, the ICB has £17m savings to deliver. • The HCPB noted that money and funding is tight going forward and a plan is needed. Comments and questions from the HCPB included: • The HCPB recognised that breakeven position is moving savings in to risks and there is significant risk in operating plan **ACTION:** Sunil Thakker (ST) to bring an update on operating plan submission to the July board meeting, also to ask individual provider / organisations what their plans look like.
7.	**North East London Joint Forward Plan** Charlotte Pomery (CP) talked members through the circulated papers and highlighted the following points: • The paper sets out a five-year plan describing how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services and a supporting reference document providing further detail on the transformation programmes described in the main plan. • The ICB team will submit the plan to NHSE by the end of June and are now in the process of engaging across the system during April and May for the publication in June 2023. The plan will then be refreshed on an annual basis. • Waltham Forest partners have key local priorities through their Place based Partnership. These are: Centre of excellence, care closer to home, Home first, Learning disabilities and autism, Wellbeing • There is an opportunity for partners in Waltham Forest to ensure that the NEL JFP reflects locally agreed priorities. Comments and questions from the HCPB included: • The HCPB asked that big ticket items need to add up in pathways.

	• LTC leads in NEL, planned care is done in community and links with acute collaboratives as well as primary care - delivers on the ground. To ensure these deliver locally. • The HCPB flagged that the financial distribution in the document re: hospitals/ borough and capital on what the system intends to do is not stated. The ICS will need to make decisions about this. • The HCPB raised a point on how we must deliver on same day access needs to be articulated. The HCPB suggested to finalise some of the narrations and get that down to bring it all together.
8.	**The Big Conversation** Charlotte Pomery (CP) talked members through the circulated papers and highlighted the following points: • The board noted that the paper gives an overview of the big conversation work going forward. • The ICS are having conversations with local people - success measures for ICP strategies. Proposing for two main ways - surveys and outcome measure. • The survey will go out late May / early June and will build work from that and to be at place level. Comments and questions from the HCPB included: • The HCPB raised questions about themes of what people are asking and commenting on. Complex needs - how that's articulated and getting a response? Is this going to do be done in a way for those who don't speak English and can't access technology? Is there a target figure in mind? The response to that was - not sure how many people will pitch up and the survey is an open opportunity for dialogue and will be accessible for BSL. it will be recurring for people to be involved for future. • The HCPB flagged there's already a focus on refugees and asylum seekers. It was suggested to link the big conversation and plan to do it locally with neighbourhoods, work around how to build co-production partnership wide.
9.	**Any Other Business:** • The June meeting will be used a development session. HCPB members to let SB and RC know if they have any thoughts / plans for this. • Photos were taken at today's meeting to bring back to public board meeting in July 2023 **ACTION:** Sue Boon (SB) to consider where and how to have a WF system discussion re access to Dentistry and for the Board to be informed of the issues.
	Date of next meeting: Monday 03 July 2023, 1130-1330 at Board Room, Junction 6, Whipps Cross Hospital

Waltham Forest Health and Care Partnership Board Action Log

Action Ref	Action Raised Date	Action Description	Action Lead(s)	Action Due Date	Action Status	Action Update
0603-01	06 March 2023	**NEL Community Health Collaborative** 1. SD to share data comparison within NEL and National for waiting times for children.	Selina Douglas	TBC	Open	Will obtain data from the ICB. Will ask NELFT to run a report as the ICB dont have the info as we upload across NEL.
0603-05	06 March 2023	2. SD to share statistical information around health inequalities and how different diverse population access services and where they access mental health services	Selina Douglas	TBC	Closed	2 open sessions planned for June/July final recommendations to come to board in Sept. Closed and placed on forward plan - linked with action 0603-08.
0603-07	06 March 2023	4. SDF – System Development Fund. (Transformation Funds) information to be shared which explains SDF.	HCPB members	TBC	Open	
0603-08	06 March 2023	5. SD to bring diagnostic results to a future board meeting. For consideration as a development workshop.	Selina Douglas	TBC	Closed	2 open sessions planned for June/July final recommendations to come to board in Sept. Closed and placed on forward plan - linked with action 0603-05.

North East London Health & Care Partnership

NHS
North East London

Homeless Health in Waltham Forest

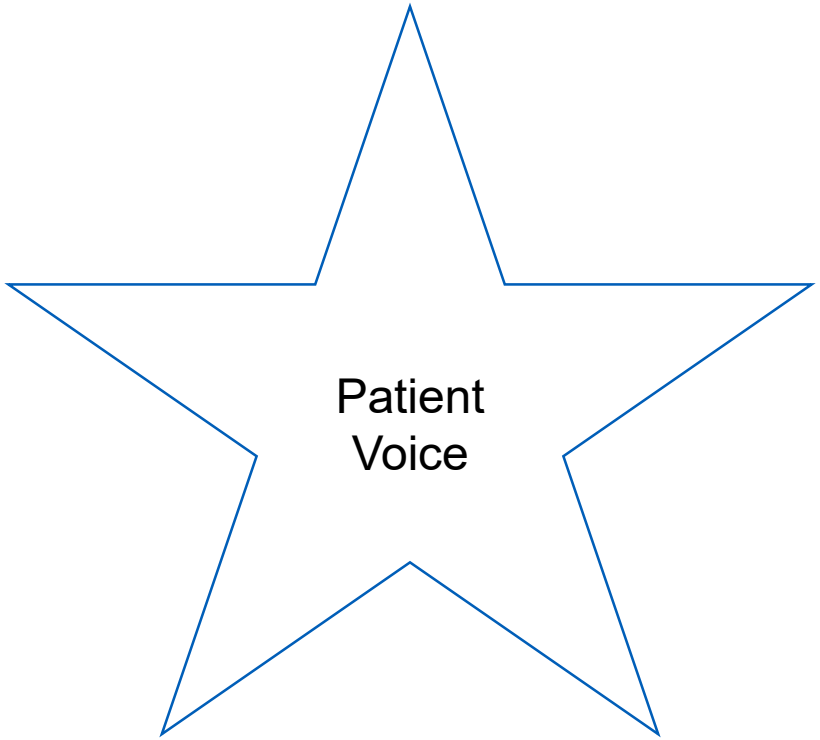
Author – Kelvin Hankins, Deputy Director of Unplanned Care

Presented by – Kelvin Hankins, Deputy Director of Unplanned Care

Dr Claire Rees, Clinical Lead for Homeless Health

Monday 3 July 2023 Waltham Forest Health and Care Partnership Board

Executive Summary / Summary of Key Issues:	Purpose of Paper / Ask of the Board:
• The numbers of rough sleepers and those in temporary accommodation are increasing locally and nationally. • Following a self-assessment we have identified a number of challenges in the delivery of healthcare in Waltham Forest, this includes a gap in provision of primary healthcare, challenges in discharging people to a suitable location following admission to physical or mental health hospitals, end of life care provision and engagement with people who are homeless on the delivery of services they receive. • There is a significant gap in provision of primary healthcare for people experiencing homelessness who struggle to engage with mainstream primary healthcare. • Proposed priorities for 2023/24 Homeless Health Transformation and the development of a partnership group on homeless health. • Proposal for a GP outreach programme in addition to the current nurse outreach programme with MDT involvement and co-production through homeless peer advocates.	For noting and decision: 1. Note the contents of the report 2. Support the development of a Homeless Health Reference Group to lead on the priorities for 2023/24 3. Comment on and/or endorse the proposed priorities for 2023/24. 4. Endorse the proposal to pilot a new model for primary care, subject to full business case process.
Engagement:	**Specific Risks:**
• The contents have been developed following engagement with health, housing and social care partners through the self-assessment. • As recognised within the self-assessment we have not done sufficient engagement with people in receipt of services, which is a priority for 2023/24	• Low engagement of patients- we anticipate it will take time to build the trust of patients and initially most appointments will be on-the-day with pro-active reach out to patients. • Long term sustainable funding


Patient
Voice

Defining homelessness in NEL

ROOFLESSNESS

Without shelter, sleeping rough on the streets

HOUSELESSNESS

Place to sleep but it's temporary, in institutions or a shelter including refugee and asylum seekers

LIVING IN INSECURE HOUSING

Threatened with severse exclusion due to insecure tenancies, eviction, domestic violence, or stating with family and friends

LIVING IN INADEQUATE HOUSING

In caravans on illegal campsites or extreme overcrowding

North East London context – Geography and numbers: Rough sleepers

This map shows the numbers of those identified as rough sleepers across the 7 NEL places

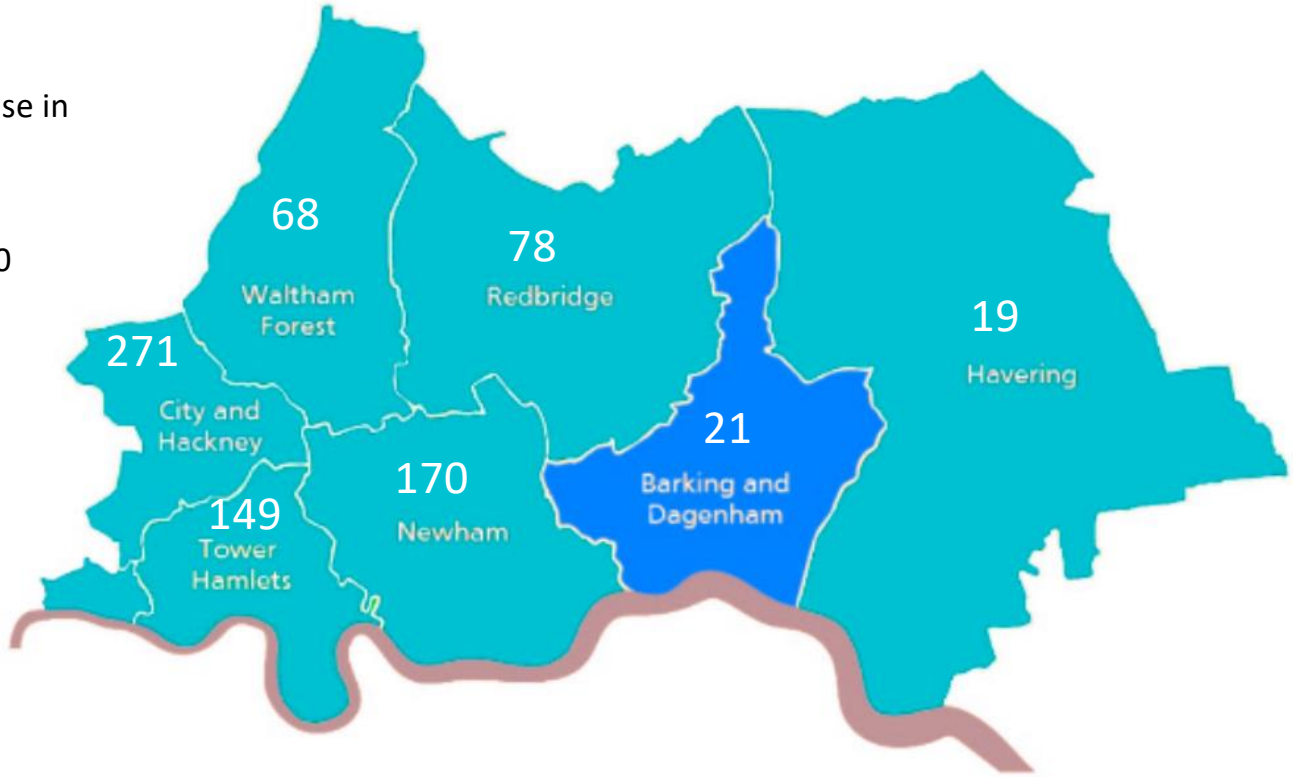
CHAIN data from Oct-December 2022 records 776 individuals sleeping rough on the streets of NEL

In comparison to the same period last year, there has been a 12% increase in rough sleepers across NEL.

Barking & Dagenham was the only place which has seen a reduction (~10 people) since the same time last year.

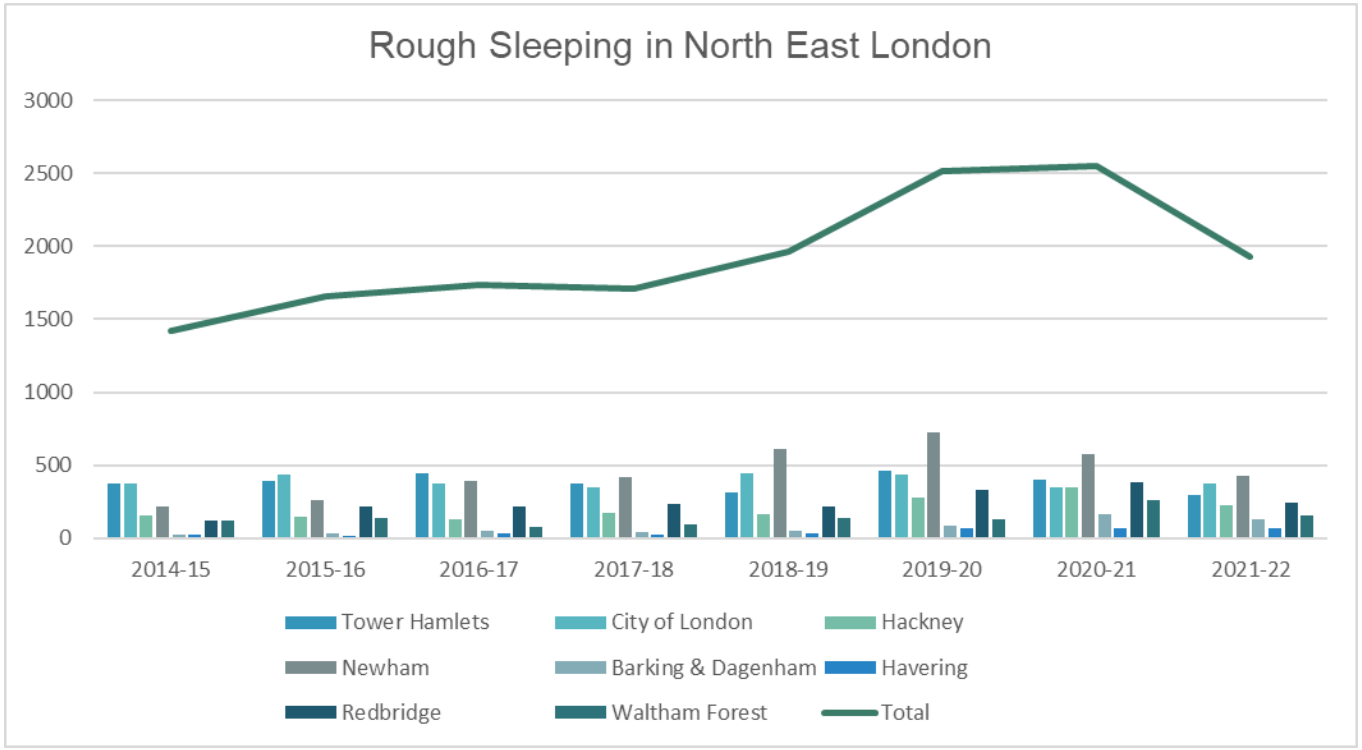
There are greater numbers of rough sleepers in the inner boroughs with City of London and Hackney representing 31% of the total for NEL

Rough sleepers are likely to be the most resource-intensive on an ongoing basis, due to the complexity of their support needs and the need to be proactive to ensure their engagement with health services



Rough Sleeping in NEL since 2014

- Since 2014, there has been a year on year increase in rough sleeping in North East London until 2020.
- During the COVID-19 pandemic there was a decrease in rough sleeping due to an increase in government funding for those experiencing homelessness via schemes such as the 'Everyone in' campaign and the 'Rough sleepers initiative'
- However, between 2014 and 2022 there has been an increase of 36% of those rough sleeping
- The Department of Levelling up, Communities and Housing estimates that the number of rough sleepers in 2022 could have risen by up to 25%



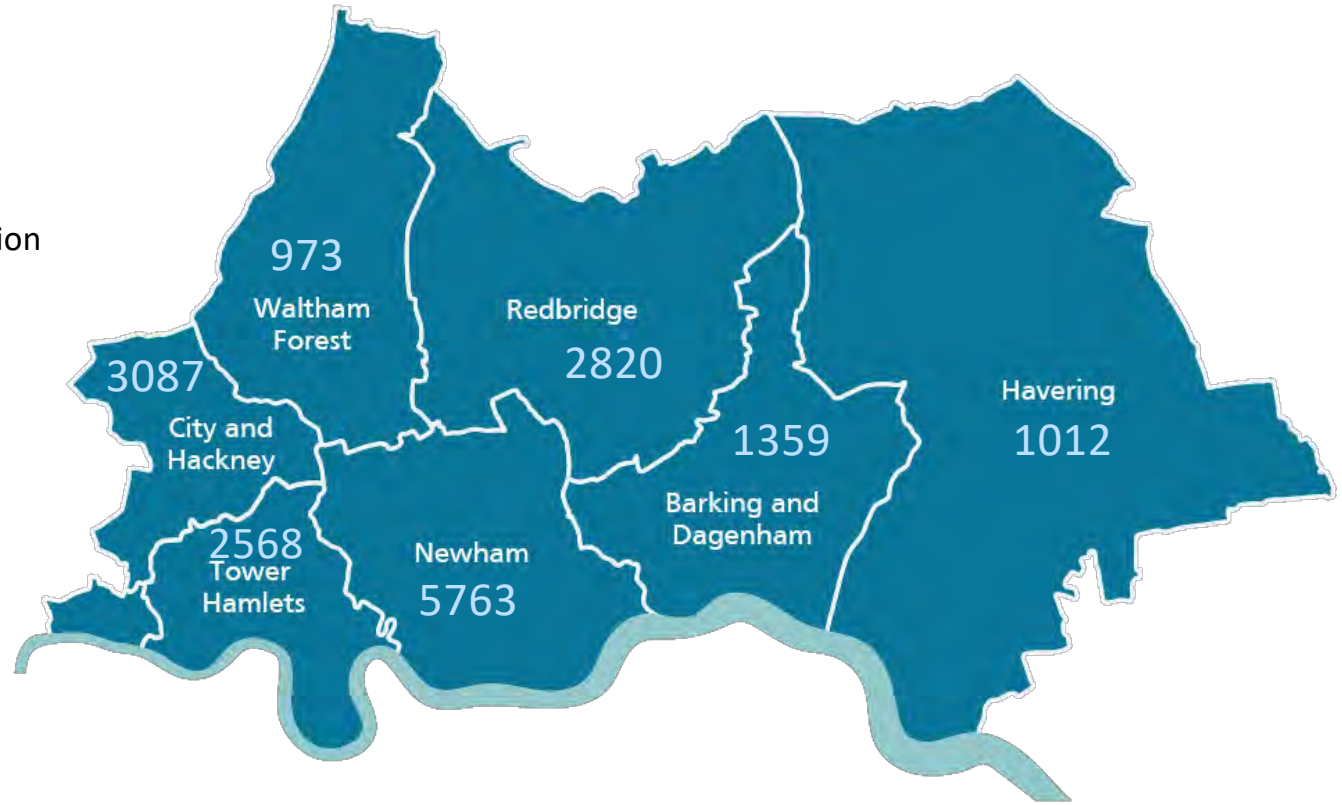
North East London context – Geography and numbers: Temporary Accommodation

This map shows the numbers of those living in temporary accommodation across the 7 NEL places

As of June 2022, there were 17,582 households in NEL living in temporary accommodation. This includes 22,468 children including 2,624 under 5s.

This made up almost 20% of those living in temporary accommodation across England.

There are approximately 6,190 households in the least secure form of accommodation (nightly paid and bed and breakfast),



Waltham Forest in June 2023

As of June 2023 there are:

- Currently 26 former rough sleepers housed in Temporary Accommodation.
- At the end of April 2023 there were 858 households in Temporary Accommodation. There has been a long term reduction in the number of households in Temporary Accommodation over several years. However, this number is likely to rise this year.
- The majority, 52%, of households were housed in-Borough, 43% in a London Borough, and 5% out of London.
- The overwhelming majority of Temporary Accommodation is self-contained, with a very small proportion with shared facilities.
- There were over 1400 children <16 in Temporary Accommodation .

Health Challenges

Chronic disease and long-term conditions

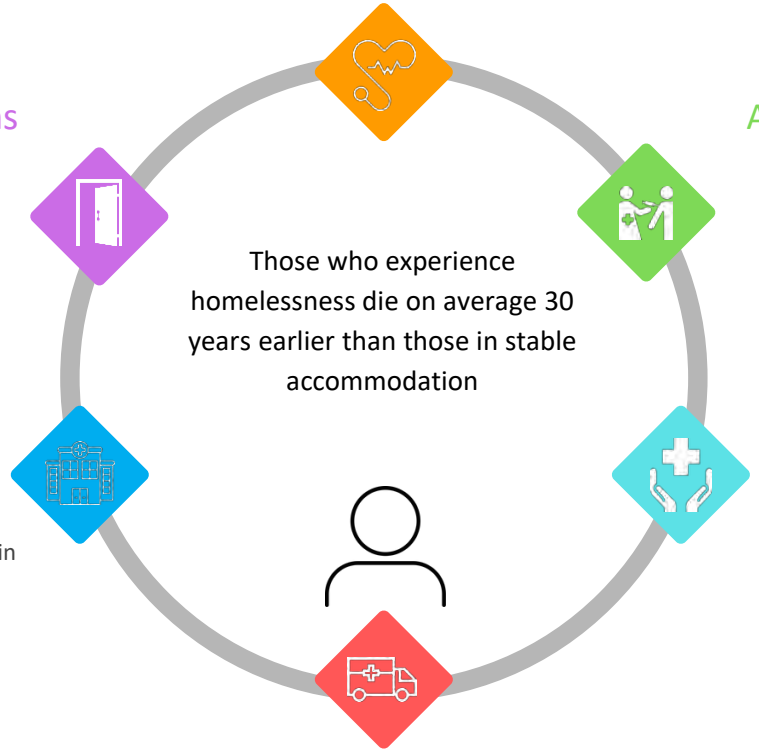
High levels of undiagnosed/untreated chronic disease.
Poor long-term condition management. – this gives the group a 'health age' equivalent to a population aged 70-80.

Hospital re-admissions

Homeless patients discharged after an emergency admission were readmitted within a year, at almost double the rate of those with homes.

Access to primary care

23% of those experiencing homelessness are not registered with a GP



Hospital admissions

4 times more likely to be admitted and stay in hospital 3 times longer than the general population

Increased vulnerability

38% of those identified as homeless in London are registered as having a condition that makes them vulnerable

A&E attendances

6 times more likely to attend A&E

Wider NEL Challenges

Funding challenges

- Multiple funding and commissioning sources
- A number of services are funded through short-term bid funding ending at various points
- NRPF and differential impact; access to accommodation and support

Data Challenges

- Inconsistent data
- Lack of integrated data sets

System Challenges

- Access, experience and outcomes – primary and community health services (e.g. dentistry, cancer screening, district nursing)
- Ability of mainstream services to accommodate complex cases
- Intersectionality (e.g. gender and links with Violence Against Women and Girls)
- Borough context and LA provision of services

Improving the health outcomes of the homeless in North East London – emerging vision and priorities 23/24

Scope

Those experiencing homelessness includes; rooflessness (without a shelter, sleeping rough on the streets); houselessness (place to sleep but its temporary, in institutions or a shelter including refugee and asylum seekers); living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends) ; and living in inadequate housing (in caravans on illegal campsites, extreme overcrowding)

Outcomes

To ensure the vulnerably housed in NEL have integrated health, housing, care, employment and community pathways that support a sustainable move away from homelessness resulting in improved health and social outcomes and a reduction in premature mortality.

Our approach

Population health management approach which is data and evidence driven

Our values

Trauma informed
Co-produced

Emerging Priorities	1. Equity across NEL identifying gaps in provision in outer boroughs and addressing unmet health needs accordingly • NEL outreach review • WF primary care review • Clinical leadership	2. Improving pathways for hospital discharge and step-down - OOHCM evaluation and business case OOHCM • Community of practice • OOHCM – NEL Bed base modelling / review	3. Improving access to primary and community provision • Registration - safer surgeries • universal proportionalism for health inclusion groups – MDT/ Care planning • Outreach review • Roll out of EMIS template to improve coding	4. Development of integrated specialist services across NEL • Co-occurring conditions review • RAMH	5. Preventing young people experiencing homelessness - System working to identify opportunities to prevent homelessness up stream – to be scoped	6. Supporting refugee and asylum seekers and those with no recourse to public funds • Estab NEL RAS working group • Outreach / pre-assessment model • Social prescribing / care navigators • Vaccination / imms
Enablers & required infrastructure	Workforce: staff health & well-being, building communities of practice and training on trauma informed care	Data, impact assessments, IT systems, information sharing agreements, primary care / acute coding	Co-production, peer support and lived experience	Addressing wider determinants of health through partnership working		

National Policy and guidance

NICE Guidance on Integrated health and social care for people experiencing homelessness:

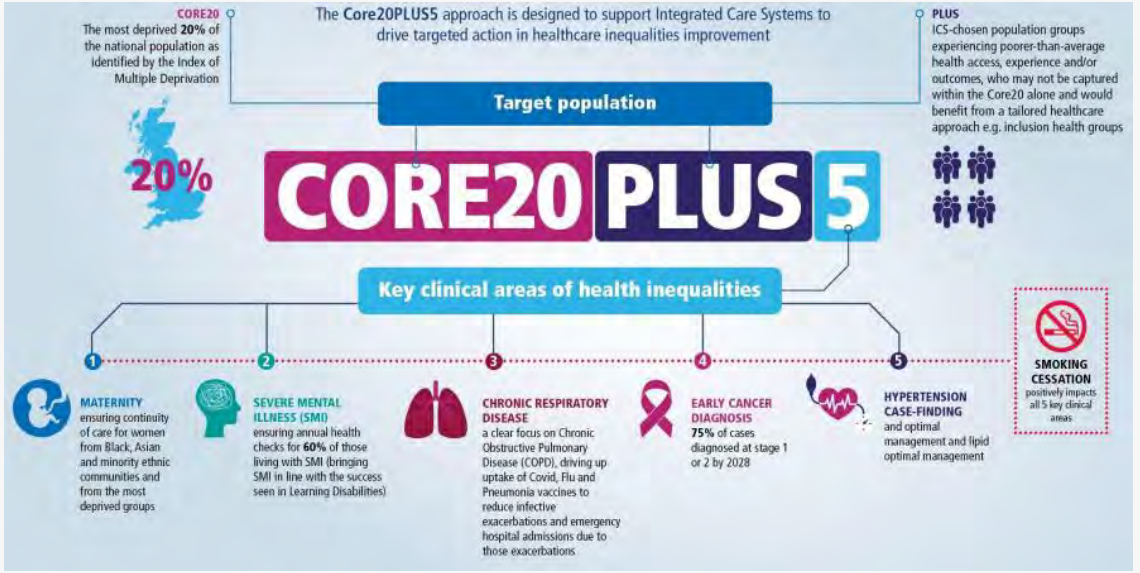
Some key points were:

- People who are experiencing homelessness and rough sleeping often require more targeted approaches to ensure that health and social care is available and accessible
- Care should be empathetic, trauma-informed and person-centred
- “Commissioners of health, social care and housing services should work together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness, and involve commissioners from other sectors, such as criminal justice and domestic abuse, as needed.”
- “Take health and social care services to people experiencing homelessness by providing multidisciplinary outreach care in non-traditional settings, such as on the street, hostels or day centres.”
- Recognise the value of co-designing and co-delivering services with people with lived experience of homelessness.

Health and Wellbeing Board guidance:

Inclusion Health is included in guidance for Health and Wellbeing Boards, making it clear that Boards and JSNAs should be considering a broad range of issues, including inclusion health populations:

National health inequalities priorities



The national healthcare inequalities programme has identified five priorities:

- Restoring NHS services inclusively,
- Mitigating against digital exclusion
- Ensuring datasets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability

The evidence based Core20 PLUS 5 framework defines key population groups and clinical focus areas for accelerated improvement in healthcare inequalities.

Homelessness

	Place-based Partnerships	Provider Collaboratives	ICB teams
	Coordinating partner	Supporting Partner	Supporting Partner
Relevant Functions	- Demand mgt - Embedding use of local data and insight from those with lived experience in planning - Ensuring equity of access - Local planning and design of service to meet pop needs – involving all relevant partners including local authority, VCSE residents as well as NHS - working with primary care to develop a local enhanced service for homelessness - development of an outreach/health inclusion team, - Ensuring evidence and data resources are available and used working on population health with PCNs - working with LA partners to identify people/families in temporary accommodation/hostels/hotels, - responding to local pressures with new refugee populations. - Identifying and tackling staff health and wellbeing for frontline staff	- Minimising unwarranted variations in outcomes - Evaluating inequalities - Sharing best practice – what works - Minimising variation between boroughs - Assessing and mitigating against inequalities in e.g. waiting lists, DNAs, cancellations as part of a proportionate universalism approach to health inclusion groups - Identifying wider population health needs of health inclusion groups and working to tackle these (using e.g. MECC and embedding prevention initiatives) - Working with places to funnel support to teams/pathways to enable them to take responsibility for and identify actions to tackle inequalities for health inclusion groups - Support work on staff health and wellbeing	- Evaluating NEL system equity – levelling up - Developing NEL strategy to address health inclusion gap – pop small in # / high complexity – transient so not restricted to place = requires NEL approach to ensure consistency of offer - Establish NEL wide minimum standards that align to recent NICE guidelines e.g outreach, OOHC etc - NEL wide approaches that support consistent approaches that reflect transient nature of pop e.g. NEL LA criteria residency, PC coding template, definition of homelessness, system notification for under 5 in temp accommodation - Supporting population management approaches to health inclusion groups – health profiles and strategic impact assessments - Interface with regional and national bodies (NHE EI, HLP, GLA etc) on health inclusion - Co-ordination of funding opportunities
Service Transformation Area Responsibilities	- Developing the local plan – borough based homeless strategies / borough based homeless health plans - Local service design - Hyper-Integration of services on the ground – homeless health borough based for a to meet needs of population - Admittance avoidance / demand management - Ensuring equity of access	- Mitigate against identified areas of exclusion and inequity - Focus on improving access and equity for underserved groups	- Ensuring minimum standards are set at NEL level following recent publication of NICE guidelines - Ensuring consistent service offer is provided across NEL - Specialist areas were it makes sense to do things once for all 7 boroughs for a small complex population that is transient rather then 7 times differently
Working together and engaging partners in our work	- Place based partnerships working closely with LA, Providers, CVS and those with lived experience to support hyper integration to address systemic issues - PBP working closely with ICB health inclusion leads to address systemic issues, levelling up, funding opportunities etc - Involvement of residents – identify priorities and coproduce solutions	- Working in partnership with clinical networks, PBP and the ICB to understand health inclusion groups, identify barriers to access, and mitigate against impact of structural inequities, exclusion and vulnerability	- ICB to work closely with PBP to identify best practice, develop minimum standards, ensure consistent offer across NEL etc - ICB to work in partnership with PBP on specialised programmes where it is of benefit to do so - ICB to co-ordinate interface with region / national bodies and support funding opportunities for PBP
Decision Making Forums	- place based partnerships - borough based homelessness fora	- Acute Provider Alliance - Mental Health, Learning Disabilities and Autism Alliance - Primary Care Alliance ?? - Community collaborative	- ICB – board / pop health and health inequalities steering group - Vulnerably housed delivery group - Vulnerably house strategic ref group

Community Nursing Outreach Service - NELFT

In October 2020, in response to the pandemic, the Community Outreach Service was implemented to support the identification and management of people's health needs that were living in two local hostels, Lea Bridge East and IBIS Styles. The service is delivered by planned appointments and drop in sessions with North East London Foundation Trust providing the service. The original service was one post holder, funding has been agreed to increase the service to two full time posts.

The service has now evolved to support six hostels in Waltham Forest. As well as opening up to those still rough sleeping and those living in homes of multiple occupancy (HMO) / private rented. The service receives referrals from the Rough Sleepers Coordination Team, Rough Sleepers Mental Health Services, CGL Street Outreach, St Mungo's and directly from hostels and client self-referrals.

The service is provided as a one stop shop approach and provides:

- Full physical health assessment with holistic health (including mental health) and social history.
- Blood and samples (urine/sputum/swab) testing, with follow up of results
- Updating GP's with assessments/concerns/results obtained.
- Prescribing
- Sexually transmitted infection testing, pregnancy testing and Hepatitis initial testing
- Mental Health and Learning Disability initial assessments carried out where indicated (AQ10, ASD Questionnaire, GAD and PHQ)
- ECG's and doppler assessments where required
- Safeguarding and risk assessments

The service makes referrals and supports access to other teams such as mental health direct, talking therapies, CGL, Memory Services, Learning Disability Team, allied health teams, the falls team, dentistry, podiatry, leg ulcer clinic, wound clinic, sexual health clinics, optical and audiology services, smoking cessation. The service supports people to become registered with and access a local GP Practice. The service will escort clients to appointments and supporting other teams with joint visits where required.

	2022/2023 Activity	Waltham Forest
1	Number of homeless residents referred to the service.	196
2	Number of referred residents already registered with a GP.	176
2.1	% of referred residents already registered with a GP	89.79%
3	Number of referred residents requiring registration	24
3.1	% of referred residents requiring registration	10.21%
4	Number of patients offered referral to GP registration upon discharge	38
4.1	% of patients offered referral to GP registration upon discharge	19.38%
5	Number of patients who have accepted GP registration upon discharge	28
5.1	% of patients who have accepted GP registration upon discharge	73.68%
6	Number of patients with ongoing care needs upon discharge	71
6.1	% of patients with ongoing care needs upon discharge	35.85%
7	Number of patients offered a health assessments	147
7.1	% of patients offered a health assessments	75.00%
8	Number of health assessments carried out	146
8.1	% of health assessments carried out	74.49%
9	Number of assessment entered on RiO	146
9.1	% of assessment entered on RiO	74.49%
10	Number of staff trained in Conflict Resolution	1
10.1	% of staff trained in Conflict Resolution	100.00%
11	Total contacts in Period	529

Safer Surgeries in Waltham Forest

What is Safer Surgeries?

Everyone living in the UK is entitled to register with a GP and access primary healthcare regardless of immigration status

Safer Surgeries initiative, led by Doctors of the World is an initiative which supports GP practices to ensure that do not have barriers in place to support vulnerable people, this includes practices following 7 steps:

- Safe Surgeries don't refuse to register patients who do not provide proof of address documentation
- They don't insist on proof of identification
- They never ask to see a visa or proof of immigration status
- Conscious of concerns around data-sharing with the Home Office, staff do what they can to protect patient information
- They use an interpreter, if needed
- They display posters to reassure patients that the surgery is a safe space
- They empower frontline staff with training and an inclusive registration policy

In Waltham Forest we currently have 32 out of 39 practices signed up to safer surgeries. This is a significant improvement since 2020 when there were only 8 practices accredited.

Dr Claire Rees is providing support to the practices which are not accredited to encourage and provide leadership as required

Training for clinicians at Waltham Forest PLT on 13th July, training planned for non-clinicians in September

Primary Healthcare in Waltham Forest for people who experience homelessness

Situation in Waltham Forest

There is inequity in provision of primary healthcare services for People Experiencing Homelessness (PEH) in NEL. Waltham Forest does not have a specialist homeless primary care service unlike TH, Newham and City & Hackney. The rate of homelessness are increasing, for FY 21-22 annual estimated 153 rough sleepers in WF. Regarding those in temporary accommodation, in June 22 there were 973 in households in temporary accommodation (424 in-borough), with 496 placed in temporary accommodation (145 in-borough) over a 12 month period and 664 asylum seekers and refugees (Campbell Tickell 22). There are 663 permanent hostel bed spaces in WF with Emergency Severe Weather Protocol (SWEP) 8 beds (London Homelessness Atlas)

There is a nurse-led outreach service run by NELFT however this is a single nurse, she does not have access to EMIS Enterprise and is only commissioned to do initial health checks with the idea to signpost patients to mainstream general practice services but we know patients struggle to engage with the traditional model. There is no advocacy or peer-support service for homeless patients in Waltham Forest.

Proposal for a new service

We are proposing building on the existing nurse outreach programme with additional GP outreach clinics at hostel locations, with time for MDT discussions of patients and supervision and peer-support. This mirrors a service within Islington who also don't have a specialist GP resource.

NICE advise outreach services should 'take health and social care services to people experiencing homelessness by providing multidisciplinary outreach care in non-traditional settings, such as on the street, hostels or day centres.' (NICE 2022)

GP outreach clinic

GP clinic once a week to hostels in Waltham Forest by geographical area alternating between south and central borough where main concentration of hostels are

- Drop in service
- Using EMIS Enterprise, details of consultation automatically added to patient notes so it can be easily accessed by the patient's usual GP practice
- Using template to collect health data
- Referrals can be made by GP practice staff, and other sectors including support workers, housing, social care, mental health and drug & alcohol workers
- Ongoing outreach clinic provided by the Community Outreach Service involving initial patient health checks
- Provision for additional nurse follow-up appointments

We are currently looking at various funding options to enable a 12 month pilot to take place.

Engagement

- A scoping exercise has been carried out with various stakeholders mapping current service provision to the Healthy London Partnership 10 points for commissioning of homelessness services- this confirmed the need for more specialist homeless services.

- A focus group was run at Branches hostel with 13 residents. They had been staying at Branches hostel between three months and just over three years. They spoke of struggling to navigate booking appointments and problems when dealing with receptionists, some had difficulty ordering repeat prescriptions. There was a common theme of problems with digital literacy, they often used phone lines to book appointments and struggled to get through. They had really valued when Cheryl (from the Community Outreach Service) had run a clinic in the hostel and were positive about a specialist homeless primary care service.

Multi-disciplinary Team working

- NICE recognise the need for specialist homelessness multi-disciplinary teams working across outreach, primary and secondary care, including experts by experience.
- Monthly MDT to discuss complex cases with input from housing, primary care, psychiatry, social prescribing, CGL
- Discussion of patients attending hospital or being discharged
- Clinical supervision session
- GP clinic format- 6 x 30 min appointments- NICE have recognised the importance of longer contact times in developing and sustaining trusting relationships between PEH and healthcare staff (NICE 2022)

Discharge to Assess for people who experience homelessness

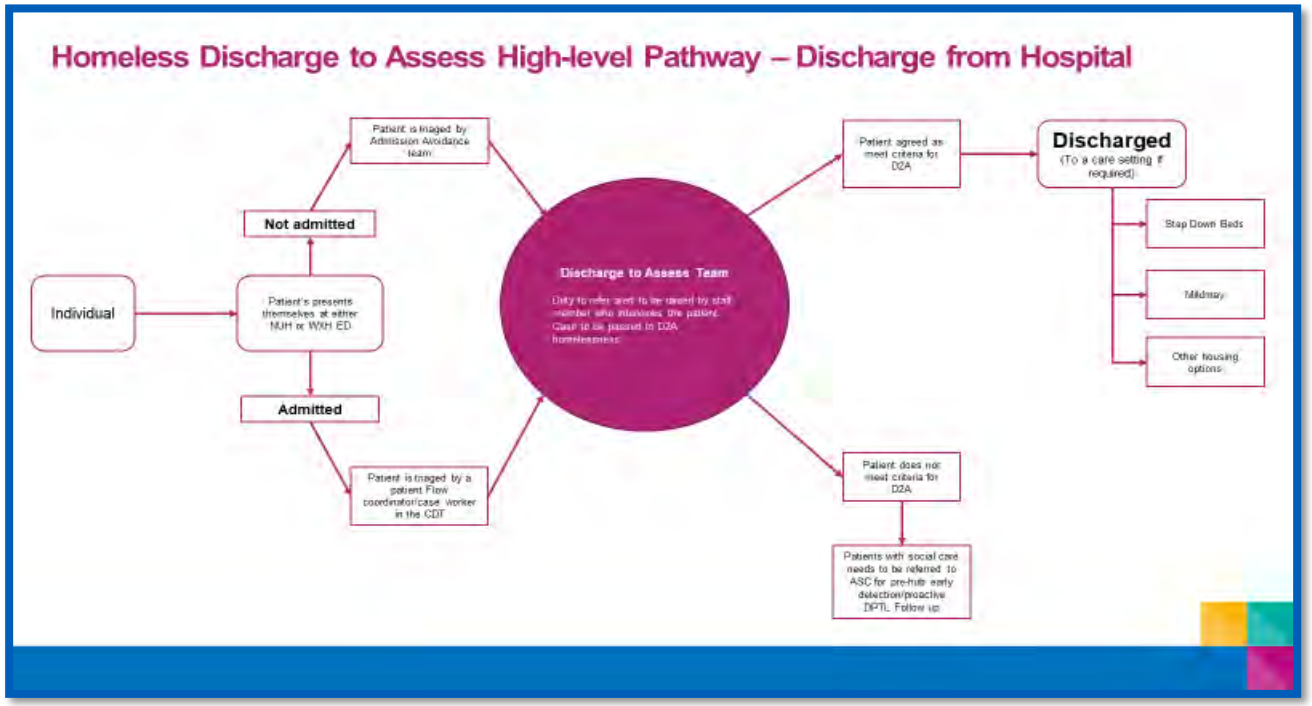
In 2022/23 North East London was awarded £1m, from the Department of Health and Social Care, to improve the discharge pathway and processes for people who are homeless but admitted to hospital by implementing a Discharge to Assess (D2A) model. Due to challenges with mobilisation the funding has been rolled over to 2023/24 and the pilot will be running until March 2024.

Waltham Forest Model for D2A

For Waltham Forest we are utilising the funding to develop a small dedicated team to be based at Whipps Cross Hospital. The team will include a social worker, nursing and administration support and will be working alongside the existing discharge teams to identify and support people who are homeless.

The team has two core roles, to support the training and education to clinical teams in the hospital to help identify people who are homeless and to act as the care coordination for people who need discharge, supporting them from the hospital to interim placements and then discharged into suitable long term.

The model is a discharge to assess model, ensuring that people are discharged from hospital, when medically fit, to interim placements. Once in the interim placement the fuller assessments and move on plans will be managed from there. The team will also support people who may choose to live temporarily with friend/family etc.



Step Down Beds

To support this model, we have also developed two step down units, shared between Newham, Tower Hamlets and Waltham Forest, which are to provide capacity to enable people to be stepped down and allow assessment and next stage planning to take place. Each placement is for a maximum of four weeks.

- Leggett House in Newham provided by Single Homeless project (5 beds)
- Gloria House in Hackney provided by Peabody (6 beds)

Identification in a hospital setting

To support the early identification of people who are homeless, that are admitted to the hospital, we have developed and rolled out a checklist which the hospital can use to support identification of people are homeless as early as possible. Where somebody is identified as homeless this person is flagged to the Complex Discharge Team to start planning for discharge linking in with Local Authorities colleagues

Mental Health support Rough sleepers Team - NELFT

The Service is for people aged 18 years and over likely to be experiencing a range of mental health needs from less complex to severe and/or enduring mental health difficulties which perpetuate their homelessness: this can include psychosis, personality disorder, depression, PTSD, Dementia and learning disabilities, with or without substance misuse. The service is particularly intended for those who have difficulty maintaining contact with services or are resistant to contact owing to the nature of their illness or previous negative experiences. There is no fixed upper age limit but for service users aged 65 years and above we would seek to work closely with other specialist services for older people.

Provide Service Across all 4 NELFT London Boroughs

- MHA assessment
- MCA assessment
- Care Act assessment
- Human Rights Act assessment
- Physical health checks
- Psychological assessment/brief intervention
- Pharmacological treatment
- Welfare rights
- Advocacy
- Housing support
- Social support
- Accessing GPs
- Safeguarding
- Joint work with drug & alcohol services

Homelessness support in WF 0.4 WTE Band 8b Psychologist. Remit includes working with hostels and other agencies supporting people experiencing homelessness and works closely with the rough sleepers team

	20/21	21/22	22/23
Total Rough Sleepers in WF	261	153	186
Total RSMH caseload for WF	35	18	23

Self-Assessment in Waltham Forest

In March 2019 Health London Partnerships issued commissioning guidance for London on the principles of healthcare for people who experience homelessness. It outlines ten commitments for improving health outcomes for homeless people. The guidance is intended to support commissioners to improve the health outcomes for homeless people in their localities, to address health inequalities and to deliver more integrated care as set out in the NHS Long Term Plan.

Healthy London Partnership 10 Commitments for Homeless Healthcare

Commitment 1	People experiencing homelessness receive high quality healthcare
Commitment 2	People with lived experience of homelessness are proactively included in patient and public engagement activities, and supported to join the future healthcare workforce
Commitment 3	Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models
Commitment 4	Data recording and sharing is improved to enhance the safety of people experiencing homelessness, enhance best practice and facilitate outcome-based commissioning
Commitment 5	Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness
Commitment 6	People experiencing homelessness are supported to access to Primary Care
Commitment 7	Mental Health Care Pathways offer timely assessment, treatment and continuity of care for people experiencing homelessness
Commitment 8	People experiencing homelessness are discharged from hospital to suitable accommodation
Commitment 9	Homeless Health advice and signposting is available within Urgent and Emergency Care Pathways and Settings
Commitment 10	People experiencing homelessness receive high quality, timely and co-ordinated end of life care

Where is Waltham Forest against the 10 commitments?

During May and June we have been undertaking a self-assessments against the 10 commitments to help inform the priorities for 2023/24 and onwards.

The self-assessment was supported with interviews with key leads across Adult Social Care, Housing, 111, NELFT Mental Health Service, NELFT Community Health Services, Hospital Services and Primary Care.

The next page details the outcomes from the self-assessment.

What did the Self-Assessment tell us

Healthy London Partnership 10 Commitments for Homeless Healthcare		Headlines of the self-assessment
Commitment 1	People experiencing homelessness receive high quality healthcare	• Each team has leads for homelessness but there is a need to create appropriate connections and forums to better connect and take a more strategic approach to the management of healthcare for this population. • There are gaps in primary care provision impacting on peoples access to reliable healthcare. • Needing to think through innovative ways to support peoples access to services where there are challenges around access.
Commitment 2	People with lived experience of homelessness are proactively included in patient and public engagement activities, and supported to join the future healthcare workforce	• There is limited evidence of the voices of service users in the delivery or design of services. • There are small examples, which could be built upon, to support people to join the future workforce.
Commitment 3	Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models	• There is not a uniform approach in organisations policies on access to healthcare services for people who experience homelessness. • Access to primary care is challenging with different approaches to adjustments and ease of access.
Commitment 4	Data recording and sharing is improved to enhance the safety of people experiencing homelessness, enhance best practice and facilitate outcome-based commissioning	• Access to data across the partnership is challenging with different services holding different data with often not a clear picture of what this tells us and how it inform service delivery. • There is not a consistent approach to collecting data on people who access services and their housing status.
Commitment 5	Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness	• Informal/semi-formal arrangements are in place between partners for the management of individual cases. • A need to explore an agree a more formal MDT approach.
Commitment 6	People experiencing homelessness are supported to access to Primary Care	• Inconsistent approach to access to primary care, with a majority of practices signed up to safer surgeries but not all. • Need to develop alternative pathways for access for hard to engage people.
Commitment 7	Mental Health Care Pathways offer timely assessment, treatment and continuity of care for people experiencing homelessness	• Local personality disorder services are in place and well imbedded • Need to take a MDT approach to discharge from acute mental health beds.
Commitment 8	People experiencing homelessness are discharged from hospital to suitable accommodation	• Step down beds in place to support discharge to assess model • Hospital based team supporting discharge in conjunction with the IDH. • Long term funding arrangement to be sourced
Commitment 9	Homeless Health advice and signposting is available within Urgent and Emergency Care Pathways and Settings	• Whipps Cross front door routinely captures housing and GP status as part of front door process. • Checklist tool in place to support identification
Commitment 10	People experiencing homelessness receive high quality, timely and co-ordinated end of life care	• Further work required to improve identification of homeless people who are at end of life and links with services to ensure rapid access to bed based and community care is in place.

Proposed Priorities for 2023/24

Based upon the self-assessment outputs, linked to North East London Priorities and Health London Partnership commitments the proposed priorities have been developed for 2023/24. It is recognised that homeless health will be a multi-year programme and will evolve over future years. Further detail and anticipated outcome to be developed

Proposed 2023/24 Priorities for Waltham Forest Place Based Partnership		Links to self-assessment
Priority 1	Using co-production to improve patient experience of services and seeking to develop a peer advocacy service.	Commitment 1 Commitment 2
Priority 2	To put in place a Homeless Health Reference Group, with responsibility for developing a multiyear programme for improvement of health services. The group will also lead on a single data approach in Waltham Forest, using this alongside resident voices to identify future priorities. Reporting to the Waltham Forest Place Based Partnership Board The purpose of the Waltham Forest Homelessness Health Reference Group is to - Provide a forum for communication and collaboration between stakeholder organisations involved in homelessness health work in Waltham Forest. - Oversee performance and impact of health services for people who experience homelessness - Share information about homelessness issues in the borough - Share best practice in providing homelessness services and solutions; - Collaborate in providing effective responses to homelessness in Waltham Forest through effective and supportive joint working between organisations; and - Support the delivery and implantation of the Waltham Forest Place Based Partnership priorities for homeless health. The reference group would include representatives from the health, housing and social care system.	Commitment 1 Commitment 4
Priority 3	To progress the business case to pilot GP Outreach Clinics to support access to primary care. Increase uptake and awareness of safer surgeries in all GP practices within Waltham Forest	Commitment 1 Commitment 5 Commitment 6
Priority 4	Build upon existing work to imbed multi agency approach to discharge for people who are homeless from physical and mental health hospital beds.	Commitment 7 Commitment 8
Priority 5	Link the homelessness health programme with the Whipps Cross End of Life Care Programme to ensure that people who experience homelessness are in receipt of end of life care services.	Commitment 10
Priority 6	Recruitment of a dedicated Transformation Officer for Homeless Health and Care in Waltham Forest	Commitment 1 Commitment 3 Commitment 4

North East London Health & Care Partnership

NHS North East London

Community Transformation programme highlight and exception report

Author – Pat Smith, Programme Director

Presented by – Pat Smith, Programme Director

Monday 03 July 2023 Waltham Forest Health and Care Partnership Board

Executive Summary / Summary of Key Issues:

The slides outlines the progress of the Integrated Care Programme in Waltham Forest, building on the aims and aspirations of the Integrated Care Programme business case. This includes updates on the following: **Home First, Care Closer to Home and Centre of Excellence.**

The slides include Quarter 1 programme status summary against the 2023/24 detailed implementation plans for the transformation programme.

Purpose of Paper / Ask of the Board:

The Waltham Forest Health and Care partnership Board is asked to:

- Note the latest updates, progress and risks within the Home First, Care Closer to Home and Centre of Excellence Integrated Care Programmes.

- Note the Programme Status Summaries.

Engagement:

- These highlight reports have been discussed internally within the integrated care transformation group meeting, Care Closer to Home Executive Meeting and Home First Executive Meeting and Centre of Excellence Executive meeting.
- This paper is to be shared throughout the WF PbP and other relevant meetings.

Specific Risks:

- **Care Closer to Home**
  Risk stratification platform –. Project being managed by Data Services and System Development team. Need to review IG implications.
- **Centre of Excellence:**
  Ongoing review of Centre of Excellence modelling, diagnostics and estates requirements taking place. Funding for estates not included in integrated care business case.
- **Home First**
  The change of community equipment provider from Medequip to Nottingham Rehab Service (NRS) is having an impact on service delivery and residents. High level discussions are taking place at a Consortium Level and Waltham Forest Level to mitigate impact.

Highlight Report: Home First Programme

Completed by:	Harry Peacock
Date:	3rd July 2023
Submitted to:	WF Health & Care Partnership Board

Project Summary: To support safe and timely discharge from hospital, prevent hospital admission and premature admission to a care home and maximise independent living.

Project Phase: Planning & Development | **Implementation** | Monitoring & Evaluation

Overall Programme Status

Project Health Status

Resources	
Delivery	
Cost	

Issues & Escalations

The change of community equipment provider from Medequip to Nottingham Rehab Service (NRS) is having an impact on service delivery and residents. High level discussions are taking place at a Consortium Level and Waltham Forest Level to mitigate impact and return to expected service levels. The handover from the incumbent provider has not been ideal and legal advice is being sought.

Key achievements and progress to date

Programme
- On-going discussions with Senior Delivery Owners around signing off their plans. Funding for 2023/24 agreed.

Admission Avoidance:
- Workshop 1/6/23 to walk through a real-life patient journey and identify where this could be improved to inform the next steps on identifying initial integration opportunities.
- **Rehab, Reablement & Recovery**
- NELFT financial costings for endorsed option developed. Finance summary to be presented to the Home First Executive for discussion/next steps.

Discharge to Assess
- Final draft of the plan developed.

Virtual Ward
- WF Frailty Virtual Ward Standard Operating Procedures (SOP) drafted.

Next steps & key upcoming milestones	Expected Completion Date
1. Programme – Get Delivery Owner Sign Off and complete Q1 updates.	1. 30th June 2023
2. Admission Avoidance – Complete Service Mapping and Scope Future Admission Avoidance Model	2. 30th June 2023
3. Reablement, Rehabilitation & Recovery – Home First Executive discussion on costs and next steps	3. 30th June 2023
4. D2A – Sign off plan and agree action owners, set up D2A Task & Finish Group	4. 30th June 2023
5. Virtual Ward – Transition from current virtual ward to new Frailty Virtual Ward Model. Mobilisation of new Frailty Virtual Ward and sign off of the SOP	5. 30th June 2023

Risk	Mitigation/s	RAG
There is a risk around the impact on residents and practice related to the change of community equipment provider from Medequip to Nottingham Rehab Service (NRS) under the London Consortium contract and a poor transition from the incumbent.	On-going discussions between Commissioning, Operations, NRS to ensure the service levels required are achieved as quickly as possible. NRS to engage additional resources to meet system needs, including 24-hour recycling and cleaning. Log and monitor incidents, issues and impact and consult with legal services	
Failure to engage staff and to deliver new ways of system working	Agree key messages going forward. Informal and formal staff engagement.	
Failure to engage with the WF Residents	Wider programme engagement and Healthwatch will be doing work with residents and carers	
There is a continued impact on community therapy resources and waiting lists from acute therapists not being able to do work outside of the hospital as envisaged in the Hospital Discharge and Community Support : Staff Action Cards	Senior management staff from Whipps have joined the Home First Operational Leadership Group. Joint rotations between acute and community therapy to take place. Workshop in May 23 around moving towards an Intermediate Integrated Community Therapy model. Follow up workshops to be held.	

Home First Recruitment Tracker – 2023/24

Completed by:	Harry Peacock
Date:	3rd July 2023
Submitted to:	WF Health and Care Partnership Board

Admission Avoidance

Intermediate Care Team	Organisation (LBWF, NELFT, PCN etc)	Banding/Pay point/Pay grade	WTE in 2023/24*	Annual Cost £'000*	Update
Medical - GP			1.0	£118	
Nursing/Therapy	NELFT	Band 7 Intermediate	7.3	£353	
Social Care	LBWF	LA PO3 SW Intermediate	2.6	£128	
Admin	NELFT	Band 4 Top	0.8	£25	
Personal Support / Reablement	LBWF		** Costs calculated @ £18/hour	£175	Monies will go to LBWF
			11.7	**£800**	

Rehab, Reablement and Recovery

Intermediate Care Team	Organisation (LBWF, NELFT, PCN etc)	Banding/Pay point/Pay grade	WTE in 2023/24*	Annual Cost £'000*	Update
Nursing/Therapy	NELFT	Band 6 Intermediate	2.0	£90	
Social Care	LBWF	LA PO3 SW Intermediate	1.8	£90	
Admin	NELFT	Band 4 Top	0.1	£3	
			4.0	**£183**	

Virtual Ward

Intermediate Care Team	Organisation (LBWF, NELFT, PCN etc)	Banding/Pay point/Pay grade	WTE in 2023/24*	Annual Cost £'000*	Update
Medical - GP			1.8	£202	Agreed that monies will be transferred to Virtual Ward budget at the outset.
Nursing / Therapy		Band 7 Intermediate	8.3	£419	
HCA		Band 4 Top	0.7	£24	
Admin		Band 4 Top	0.6	£20	
Personal Support / Reablement			** Costs calculated @ £18/hour	£33	Monies will go to LBWF
			11.4	**£698**	

*Total WTE funded by programme at end of 2023/24.

Highlight Report: Care Closer To Home

Workstream Lead:	Vicky Kankam – CC2H Transformation Lead
Date:	3rd July 2023
Submitted to:	WF Health & Care Partnership Board

Project Summary: To deliver proactive, integrated community care by providing early coordinated support and joint decision making for those more likely to use hospital services

Overall Workstream Status

Project Health Status

Resources 

Delivery 

Cost 

Key achievements and progress to date

Care Homes
- 14 Care homes successfully running MDT meetings
- Engaged and in discussion with Commissioning Lead for St Catherine's Rest Home to assist with implementing MDT meetings.
- Successfully on boarded Mapleton and GML with Alliston House to undertake joint MDT meetings.
- Developing a QI process to review Year 1

Anticipatory Care MDT
- Successful roll-out of Pilot Anticipatory Care MDM at Addison Road Practice, continue with roll over.
- Next Addison Road MDT scheduled for 5th July
- Engaged and in discussion with GP Lead for Penrhyn surgery on piloting anticipatory MDT.
- 9th June held shoot day for PCN MDT video

Risk Stratification
- Continue engagement with Project Team in the development of the risk stratification dashboard
- As an interim measure, we are using stratified data that formed the basis of the assumptions of BC

Key achievements and progress to date

LTC Management
- Identified priority areas of delivery for Diabetes
- Meeting scheduled with NELFT Head of Planned Care Lead to discuss Diabetes Education Course Audit
- Developed LTC templates for high prevalence disease areas (Hypertension, AF, COPD) and shared with stakeholders for feedback on identified gaps.

Primary Care-led Mental health Liaison
- Workshop with MH Transformation Team held on 19th May to discuss opportunities for collaboration, follow up meeting planned to agree next steps.
- First T&F MH Liaison to take place 4th July

Enhanced Domiciliary Care Support
- Engaged with Integrated commissioning team on 20th April. Lead identified to work with Home First and CC2H Programme leads to identify priorities for delivery
- Follow up meeting planned in June

Escalations / Noting

- For Noting

Primary care SNS launch in July 2023, impacting the delivery of PCN MDT.

There is a potential issue with the use of NELIE, the Programme Team are working closely with them to resolve.

We have achieved 9% out of the expected 14% completion for Q, however It is worth noting that we have made progress in all areas of the programme.

Next steps & key upcoming milestones	Expected Completion Date
1. Continuation of Addison Road Practice Anticipatory Care MDT	**August 2023**
2. PCN MDT video distributed across system partners	**July 2023**
3. Finalisation and Launch of PCN MDT SNS, including comms campaign to engage system partners	**October 2023**
4. Continuation with discussion of Risk Stratification project	**July 2023**
5. Incorporate stakeholder's feedback on LTC Templates for high disease prevalence areas	**July 2023**
6. Conduct Care Home MDT QI Analysis	**July 2023**

Risks & Issues

Risk	Mitigation/s	RAG
Funding / Resource / Engagement : Anticipatory MDTs rely on full participation of PCNs. At present there are varying levels of engagement from PCNs. If additional funding is not made available, this will impact the level of resources needed to support the programme.	a) Work with Primary Care and LMC to develop an enhanced SNS (funding) for PCNs b) Engage with PCN/GP Clinical Leads to develop a plan for the MDT Roll-out c) Identifying search criteria for anticipatory care MDTs d) Actively communicate, listen, assess and adjust as necessary.	
Risk Stratification Criteria/Tool: If a risk stratification criteria / tool is not in place, it will put more pressure on GP time to identify the appropriate patients to be discussed at the anticipatory MDT. This can also contribute to PCN commitment in rolling out PCN MDTs.	a) Work with Clinical and GP Leads to agree a list of risk factors for patients suitable for anticipatory care b) Work with NEL Discovery platform to build on stratification process/system to agree search. c) Utilise stratified data that formed the basis of the assumptions of the Business Case	
Data: There is risk of not accurately monitoring patient journey due to incomplete data from GP practices/PCN.	a) Confirm National DES requirement around Care Home data submission b) Recruit MDT Care Coordinators as part of the SNS agreement c) Share DSCRO templates with MDT CC and agree submission deadlines .	

Care Closer to Home Recruitment Tracker – 2023/24

Completed by:	Vicky Kankam – Programme Lead
Date:	3rd July 2023
Submitted to:	WF Health and Care Partnership Board

CC2H - CH

Core Team	Organisation (LBWF, NELFT, PCN etc)	Banding/Pay point/Pay grade	2023-24 WTE	Annual Cost £'000	Recruitment Date	Comments
Nursing	NELFT	Band 7	0.90	£58	May 2023	0.6 wte Band 7 converted to band 4 WTE
Nursing / Therapy	NELFT	Band 8a Top	1.56	£114	Jan & March 2023	Post recruited to in year 1
Medical - Staff Grade Geriatrician	Bart's Health	MF02 Point 3	0.60	£23	Sept 22	MOU in place enabling access to resource
Medical - Consultant Geriatrician	Bart's Health	YC72 Point 19	0.60	£87	Sept 22	MOU in place enabling access to resource
				£282		

CC2H - PCN

Core Team	Organisation (LBWF, NELFT, PCN etc)	Banding/Pay point/Pay grade	2023-24 WTE	Annual Cost £'000	Recruitment Date	Comments
Medical	GPs contribution to MDT Working	Assume £80 per hour	1.50	£227	TBC	GPs attend the MDTs and will be paid through SNS
Nursing/Therapy (Community Matrons/OT's)	NELFT	Band 7 Top	4.60	£294	Sept-Dec 2022	2..6 Recruited in Year 1
Social care	LBWF	Band 7 Intermediate	2.00	£121	TBC	Recruitment Underway
Care coordinator	To confirm Host	Band 5 Top	10.20	£364	TBC	Recruitment to be included as part of SNS
Locality Coordinator	To confirm Host	Band 4 Intermediate	3.50	£139	TBC	Recruitment not started, exploring options to merge resource to support CC2H and COE workstreams
Medical - Consultant Geriatrician	Bart's Health	YC72 Point 19	0.60	£87	TBC	Recruitment to be included as part of SNS
				£1,232		

CC2H - MH

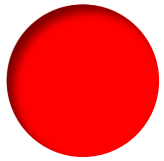
Core Team	Organisation (LBWF, NELFT, PCN etc)	Banding/Pay point/Pay grade	2023-24 WTE	Annual Cost £'000	Recruitment Date	Comments
Medical - GP	GPs contribution to MDT Working	Assume £80 per hour	0.59	£87	TBC	Post to be developed following review of pathway
Community Psychiatric Nurse	NELFT	Band 7 top	1.08	£69	Feb 2023	Post recruited to in Year 1
Social Care Worker	LBWF	Band 7 Intermediate	0.20	£9	TBC	Post to be developed following review of pathway
Voluntary Sector		Band 4 Top	1.51	£39	TBC	Post to be developed following review of pathway
Housing Liaison Officer	LBWF	Assume £33 per hour	0.21	£9	TBC	Post to be developed following review of pathway
Psychologist	NELFT	Band 7 Top	0.27	£13	TBC	Post to be developed following review of pathway

Highlight Report: *Centre of Excellence*

Completed by:	Sharif Ahmed, Programme Lead, NEL ICB
Date:	3rd July 2023
Submitted to:	WF Health & Care Partnership Board

Project Summary: Remote monitoring, holistic support for LTCs and complex patients, wellbeing support and cross-professional training and leadership development.

Project Phase: Planning & Development | **Implementation** | Monitoring & Evaluation

Overall Project Health	Project Health Status
	Resources  Delivery  Cost 

Issues & Escalations

- **FOR INFO:** Original Digital Hub programme plan for year 2 is c.2.5-3 months behind plan. All year 2 milestones still expected to be achieved within year 2 and actions expected to accelerate once clinical model is designed. Procurement and recruitment timelines will have the most significant impact on service launch timelines.

Key achievements and progress to date

Centre of Excellence
- Regular management meeting with clinical leads and SRO arranged.

Digital Hub
- Access Group demonstration workshop held showcasing potential infrastructure and tools for Digital Hub use.

LTC & Complexity Hubs
- Expression of Interest process complete, successful organisation (NELFT) notified.

Locality Hubs
- Initial estates options explored
- Health inequalities funding submission made part of which will support locality hubs development.
- Task & finish group meeting scheduled; first meeting on 26 June

Next steps & key upcoming milestones	Expected Completion Date
Centre of Excellence 1. Ensure all actions in year 2 plan have assigned leads	**Centre of Excellence** 1. End June 2023
Digital Hub 1. Complete model design encompassing telehealth/telecare, telemedicine and assistive tech 2. Decision to be taken with regards to use of clinical facilitator role (post hosted by GP Fednet via NEL funding)	**Digital Hub** 1. End July 2023 2. End June 2023
LTC & Complexity Hubs 1. Begin mobilisation process of virtual service and re-assess launch timelines for virtual service 2. Agree contract documentation with selected service host 3. Write staff JDs & calculate staffing costs 4. Agree activity metrics and collection method	**LTC & Complexity Hubs** 1. End June 2023 2. Mid-July 2023 3. Mid- July 2023 4. Mid-July 2023
Locality Hubs 1. First draft service specification to be completed	**Locality Hubs** 1. July 2023

Risk	Mitigation/s	RAG
If development of overall model of care for Digital Hub is delayed this will result in service gap which means we will be unable to fully demonstrate the impact of the Hub in year two.	Digital Hub Clinical Model Design Workshop has been established, chaired by Dr Asad Ashraf which is responsible for designing the clinical model.	
If no definitive estates plan in place, delivery of the Centre of Excellence model both on an interim and long term basis at risk	Estates discussions being held at the Centre of Excellence Executive Group meeting.	
If there is a delay in securing a service host and recruiting/reallocating staff, the launch timelines for the LTC and Complexity Hubs will be delayed.	Expression of interest released to include service host requirements and staff roles and responsibilities, being managed through T&F Group	

Centre of Excellence Recruitment Tracker - 2023/24

Completed by:	Sharif Ahmed, Programme Lead, NEL ICB
Date:	3rd July 2023
Submitted to:	WF Health & Care Partnership Board – May 2023

Core Team	Organisation	Banding/Pay point/ Pay grade	Annual Cost £'000	Expected Spend Date	Interim/Permanent	Comments
LTC & Complexity Hub						
Service Host	NELFT	TBC	TBC	Jun-23	Interim	9 month contract to December 2023
Staff						
GPwSI	NELFT	TBC	£25,721	Jun-23	Permanent	1 session per week
Community Matron	NELFT	TBC	TBC	Jun-23	Permanent	1 session per week
Care Coordinator	NELFT	TBC	£32,407	Jun-23	Permanent	1 WTE
Pharmacist	NELFT	TBC	TBC	Jun-23	Permanent	1 WTE
Social Prescriber	NELFT	TBC	TBC	Jun-23	Permanent	1 WTE
Secondary Care Consultants	Barts Health	TBC	TBC	Aug-23	Permanent	Sessions TBC
Estates						
Lease	TBC	TBC	TBC	Oct-23	Interim	
Renovations	TBC	TBC	TBC	Nov-23	Interim	
Home Visits	TBC	TBC	TBC	Jul-23	Permanent	Associated costs TBC
Digital Hub						
Service Host	TBC	TBC	TBC	Jul-23	Permanent	
Remote Monitoring Provider	TBC	TBC	TBC	Oct-23	Permanent	
Remote Monitoring Nurses	TBC	TBC	TBC	Oct-23	Permanent	
Telemedicine tech requirements	TBC	TBC	TBC	Nov-23	Permanent	
Assistive tech procurement	TBC	TBC	TBC	Nov-23	Permanent	
Training resource	TBC	TBC	TBC	Oct-23	Permanent	Role & function TBC
Wellbeing Lounge						
No expected costs for year 2						
Leadership, Innovation & Training Hub						
No expected costs for year 2						

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WF Integrated Care Transformation - Programme Status

Home First ,Care Close to Home, & Centre of Excellence

June 2023

Waltham Forest Place Based Partnership

Programme Status

- The programme status provides a summary of the current status of the programme in relation to the detailed implementation plan, project timeline completion against agreed tasks and milestones.
- The detailed implementation plan sits underneath this summary and informs the grading of the status.

Glossary

Term	Definition
Schedule	Shows progress against the timelines.
Scope	Delivery in line with the business case.
Resource	Sufficient resources to deliver the programme (excluding finance).
Risks & Issues	Risks and issues that may impact the delivery.
Budget	Allocated budget against spend.
Impact	Delivery of the business case as main outcomes measured against framework outcomes.

RAG Rating Calculator

Rag Rating Key	
100%	All completed.
75% - 99%	Where we are against the business case.
26% - 47%	Retrievable with mitigation.
0% - 25%	Activity should have started and has been delayed.
0%	Not started.

Home First Programme Status

Year 2 – Scaling Up

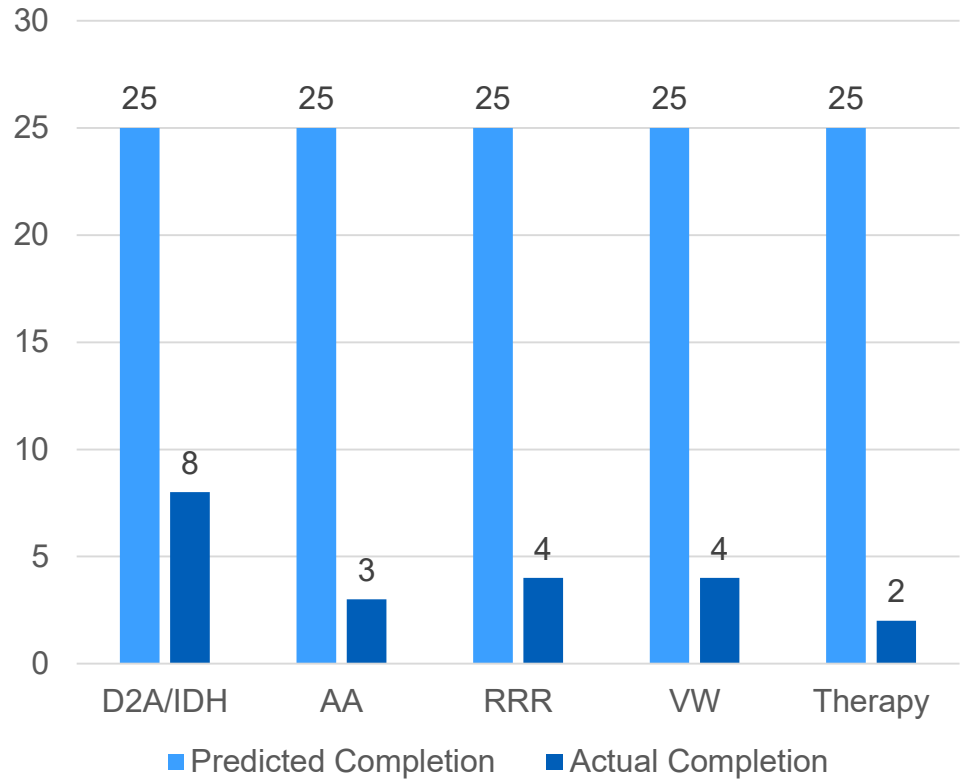
1st April 2023 to 30th June 2023

Planned % complete	Actual % complete
25%	7%

Programme Status

On Hold	0
Not Started	0
Planning	0
Design	0
Delivery	5

Programme Completion % against planned



Project	Schedule	Scope	Resources	Risk/Issues	Budget	Impact
D2A/IDH						
AA						
RRR						
VW						
THERAPY						

Programme Budget: £1,681k

Programme Spend: £TBC

Project Update	
Discharge 2 Assess/ Integrated Discharge Hub	Initial meeting held to agree 23/24 priorities which include: business case implementation, Newton D2A actions, Whipps Urgent & Emergency Care Plan 'Route 76', and Carers. Plan needs finalising and sign off. Once plan and action holders are agreed the D2A Task & Finish Group will be re-established.
Admission Avoidance	The focus this quarter has been on completing the Service Mapping and development of one page service summaries for key admission avoidance services. Workshop held 1st June 23 to walk through a real-life patient journey and identify where this could be improved to inform the next steps on identifying initial integration opportunities and medium-term developments.
Rehab Reablement Recovery	NELFT financial costings for endorsed option developed based on 3 potential resource scenarios: 60 WTE care workers, 65 and 70 to account for the predicted increase in demand over the next 2 to 3 years. Finance summary to be presented to the Home First Executive June 23 for discussion and next steps.
Virtual Ward	Work on-going to develop the SOP and project plan for mobilisation and scale up. It has been agreed to transfer this years (23/24) transformation staffing budget to the main virtual ward budget to support recruitment and staffing costs.
Therapy	Workshop held with partners (LBWF, NELFT and Acute Therapies at Whipps). Focus was on the business case direction of travel, and identifying the key issues, challenges and risks. Discussion on agreeing what the priorities over the next 3 to 6 months are and next steps. Follow up workshop to be set up.
Impact	Work continues to develop and sign off the Performance and Outcomes Framework to demonstrate impact. Further work required to evidence impact and set up deep dive analysis.

Care Close to Home Programme Status

Reporting Period	Jun 2023

Year 2, Quarter 1

1st April 2023 to 30th June 2023

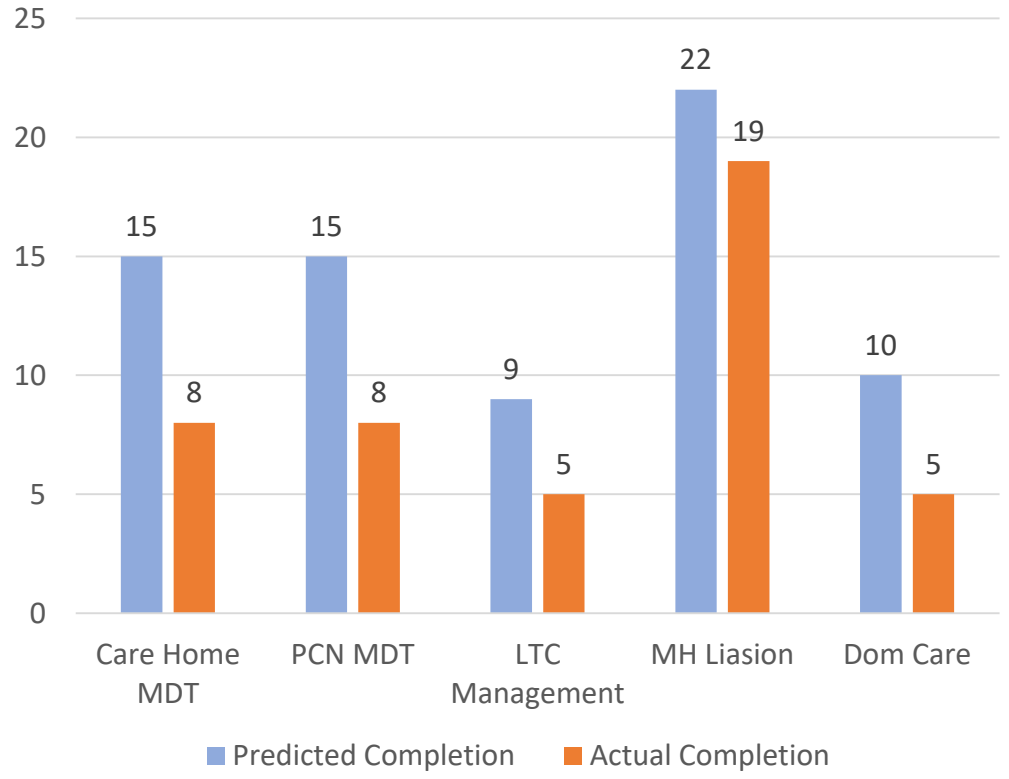
Programme Complete

Actual % Plan Complete	Planned % Plan Complete
9%	14%

Programme Status

On Hold	0
Not Started	0
Planning	2
Design	2
Delivery	1

Programme Completion % (against plan)



Project	Schedule	Scope	Resources	Risk/Issue	Budget	Overall
Care Home MDT	🟡	🟢	🟢	🟡	🟢	🟡
PCN MDT	🟡	🟢	🔴	🟡	🟢	🟡
LTC Management	🟡	🟢	🟢	🟢	🟢	🟢
MH Liaison	🟢	🟢	🟢	🟢	🟢	🟢
Domiciliary Care	🟢	🟢	🟢	🟢	🟢	🟢

Programme Budget: £1.3M

Programme Spend: £TBC

Project Update

Care Home MDT	Care Home MDTs are in delivery with 14 out of 15 Care Homes holding MDTs. Escalation plans are in place for the last Care Home. A sharing agreement with PCNs is not in place, however the Programme Team is working with Information Governance to develop an agreement. Plans are underway to conduct a QI Analysis with a report and agreed action plan in place in Q2.
PCN MDT	PCN MDTs are in the design stage. Addison Road pilot has continued which has supported in the development of a SOP , addressing concerns that could impact on a PCN level. Comms materials are being developed in preparation of the SNS launch to support with engagement. Resources flagged red due to the delay of SNS signoff and the steps involved of developing the Risk Stratification criteria.
LTC Management	LTC Management is in the design stage as the project focuses on the diabetes pathway to start. Mapping of the service complete and plans are in place to conduct an audit of the Diabetes Education which will inform delivery outcomes.
Primary Care MH Liaison	Mental Health Liaison is in the planning stage with a workshop with the Mental Health Team completed. The first T&F to take place in Q2 to review the existing Mental Health pathway.
Domiciliary Care	Initial conversations have taken place as part of the Home First programme.

Centre of Excellence Programme Status

Year 2, Quarter 1

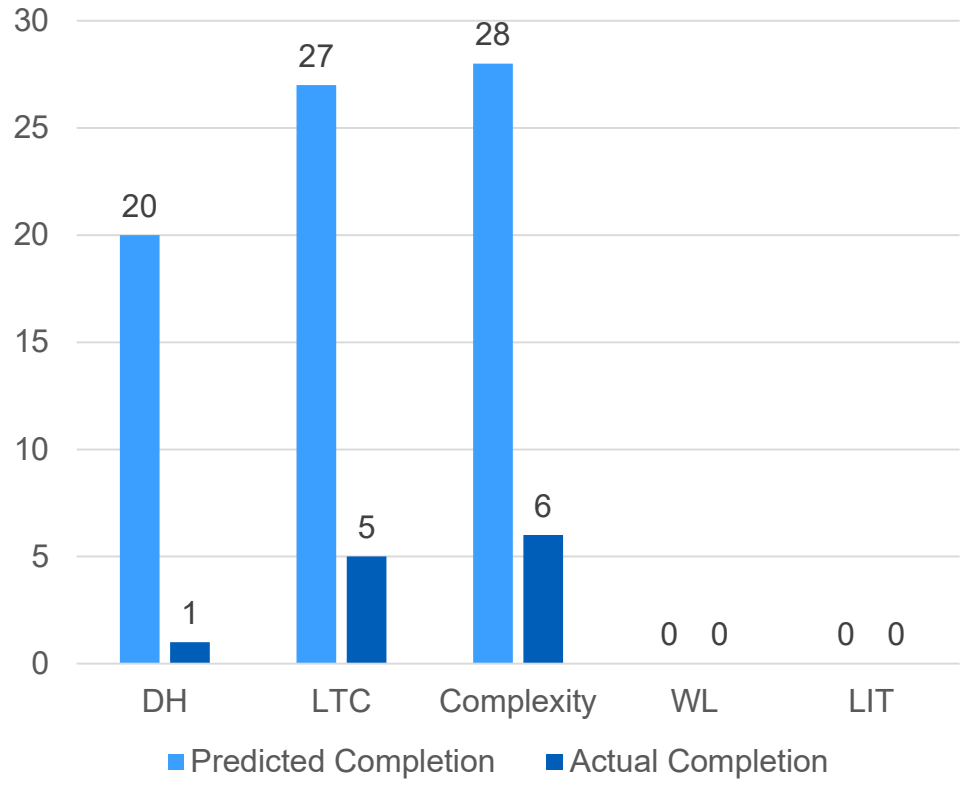
1st April 2023 to 30th June 2023

Actual % Plan Complete	Planned % Plan Complete
7%	38%

Programme Status

On Hold	0
Not Started	2
Planning	0
Design	3
Delivery	0

Programme Completion % (against plan)



Project	Schedule	Scope	Resources	Risk/Issues	Budget	Impact
Digital Hub	🔴	🟡	🟡	🟡	🟢	🔴
LTC Hub	🔴	🟢	🟡	🔴	🟢	🔴
Complexity Hub	🔴	🟢	🟡	🔴	🟢	🔴
Wellbeing Lounge	⚪	⚪	⚪	⚪	⚪	⚪
Leadership, Innovation & Training Hub	⚪	⚪	⚪	⚪	⚪	⚪

Programme Budget: £1,263k

Programme Spend: £0

Project Update

Digital Hub	Initial workshop session held to scope Digital Hub ambitions and relevancy to current population needs. Key lines of enquiry formed with particular interest in Access Group potential to provide required infrastructure to support Digital Hub. Broad demo made by Access Group on 5 May although no key Waltham Forest stakeholders able to attend. Priority is to schedule a direct demonstration by Access Group and Waltham Forest senior leaders for endorsement to engage with the provider for Digital Hub requirements. This will then subsequently inform the scope & design working group to develop the Digital Hub clinical model. This action has been delayed due to a combination of scheduling issues, bank holiday periods and annual leave which has in turn delayed the development of the clinical model. Plan to support two Waltham Forest nursing homes through remote monitoring postponed at the start of the year in favour of design of overall clinical model mentioned above. All year two milestones expected to be achieved within year although quantifying impact will be further delayed to allow for services to launch, embed and show a demonstrable impact.
LTC and Complexity Hubs	Q1 priority is to launch the interim virtual MDT. Clinical model designed, pathway agreed and roles/responsibilities articulated. Expression of Interest process complete and successful organisation (NELFT) informed. Initial meeting with NELFT to begin mobilisation process cancelled on the day due to emergency; second meeting scheduled and provided an overview of the model and answered questions/queries. Follow up session to be organised but delayed due to colleague availability. Final set of activity metrics for collation during service delivery to be agreed with NELFT. Clinical job descriptions and referral form being finalised by Dr Imran Ahmad. Dr Ahmad also liaising with Barts Health consultants to begin engagement process for secondary care input into hubs. Work to establish physical presence of service linked in with locality hub workstream, led by Dr Ken Aswani. Initial sites identified; task & finish group to meet to define requirements list covering all services including LTC and Complexity Hub needs. All year two milestones expected to be achieved within year although quantifying impact will be further delayed to allow for services to launch, embed and show a demonstrable impact.
Wellbeing Lounge and Leadership Innovation & Training Hub	Task & finish groups for both of these elements to begin in Q3.

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Programme Performance Report

DRAFT – Performance report under development

Waltham Forest Integrated Community Care Programme

Hakeem Badmus – Planning and Performance Manager

15 June 2023

Waltham Forest

Executive Summary / Summary of Key Issues:	Purpose of Paper / Ask of the Board:
The slide outlines the performance dashboard of the Integrated Care Programme in Waltham Forest, The suite of have been refreshed with latest available data with the following updates: Updated Care Home MDT slide detailing A&E attendances and Ambulance Conveyances to the individual care homes – bed capacity and date started enhanced MDT now included.	The Waltham Forest Health and Care partnership Board is asked to: • To note the attached performance framework for the Waltham Forest Integrated Care Programme.
Engagement:	**Specific Risks:**
• Continuing to work with IDF/WX Redevelopment team to ensure dashboards are aligned. • IDH readmissions data now on Power BI and first report should be ready for August Board.	• Insufficient data across the system to enable tracking of performance. Working with BI colleagues across the system to understand all data that is collected and how the programme can access those datasets

Contents

Programme performance report development

Purpose

- The purpose of the programme performance report is to monitor and track performance of the transformation schemes in the business case; and at a high level understand the impact it is having on demand into secondary care.
- In this report a direct correlation between transformation performance and reduction in secondary care demand cannot be made, however we can understand at a high level the demand that is going into secondary care, and therefore it may indicate whether the schemes are impacting on the overall A&E and unplanned care activity.
- Through an evaluation process using patient identifiers, we will be able to see at patient level the shift in care, therefore this will describe in more detail the impacts our transformation is having on our patients. We would recommend that we do this on a quarterly or 6 monthly basis based on the scheme.

Transformation schemes currently included in this report:

Programme Area	Scheme Name
Care Closer to Home	Care Home MDT
	Centre of excellence – Digital Hub
Home First	Rapid Response
	Rehab, Reablement and Recovery (Integrated Supported Home Discharge)
	IDH Improvement / Discharge to Assess

Transformation schemes not included in this report and our plan:

Programme Area	Scheme Name	Status of scheme	KPI development plan (working with clinical leads, service and delivery leads)	Expected date of reporting to board (to be agreed wit clinical leads, service and delivery leads)
Care Closer to Home	PCN MDT	Started	TBC	TBC
	Primary Care MH Liaison	Not started	TBC	TBC
	Complex LTC Management	Not started	TBC	TBC
Centre of excellence	Complexity hub	Not started	TBC	TBC
	Long Term Conditions Hub	Not started	TBC	TBC
	Wellbeing lounge	Not started	TBC	TBC
	Leadership, Innovation and Training Hub	Not started	TBC	TBC
Home First	Virtual Ward	New model not started	TBC	TBC

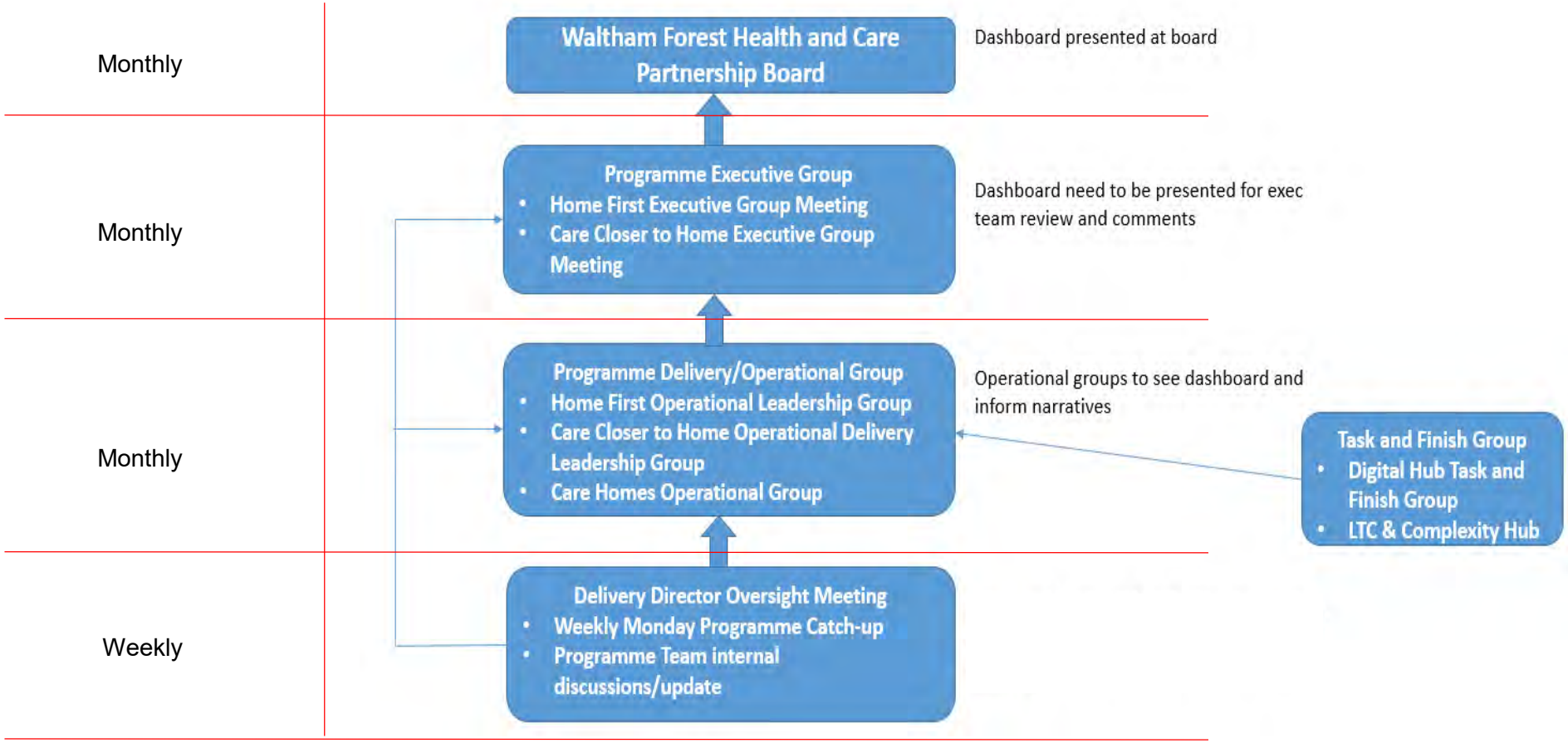
We will update the board on progress.

Reporting cycle and process

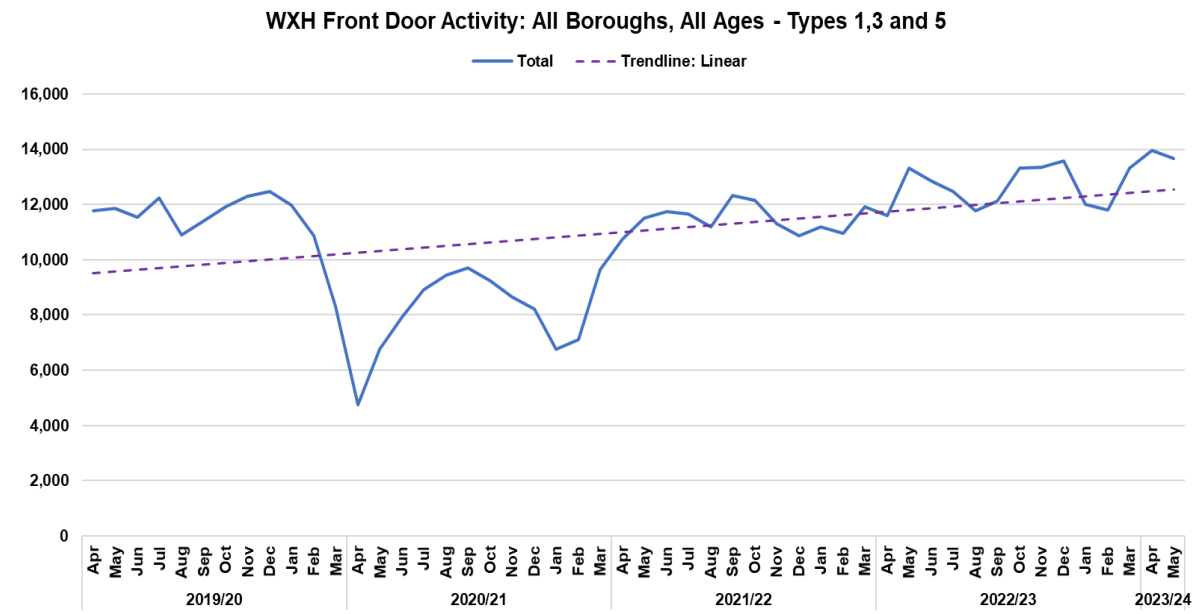
To enable more detailed and informative discussions at the board, we are proposing a flow of reporting to help understand the data in more detail, and highlight any other key issues that may be impacting on performance.

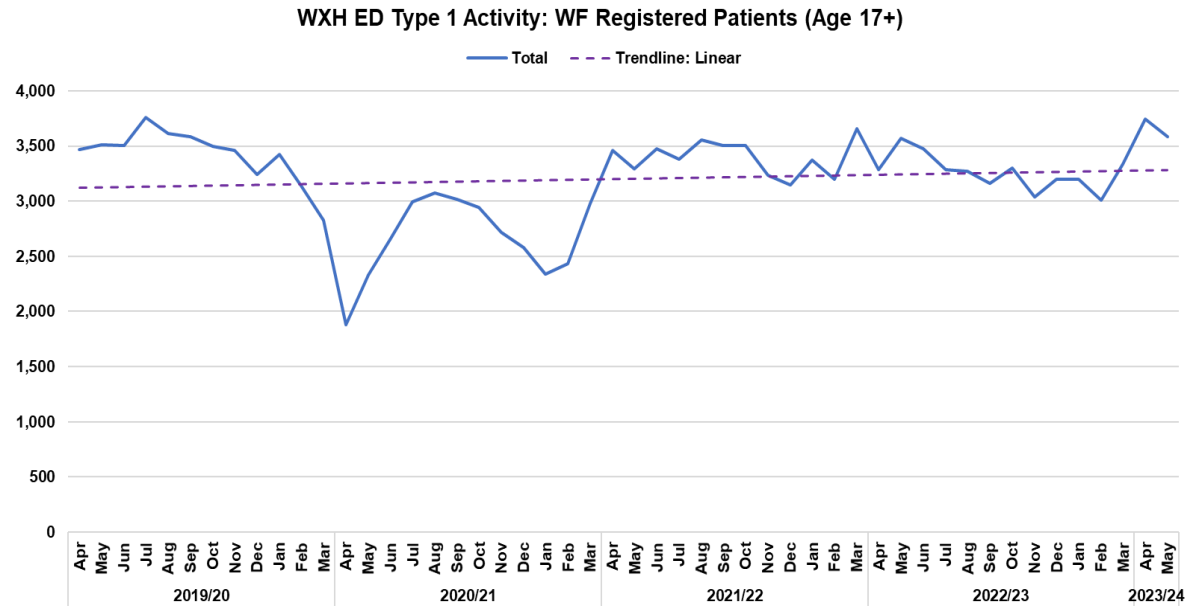
We will involve and include clinical, operational and delivery leads in this discussion to get better insight into the schemes, and provide this intelligence to support the performance data through narrative updates.

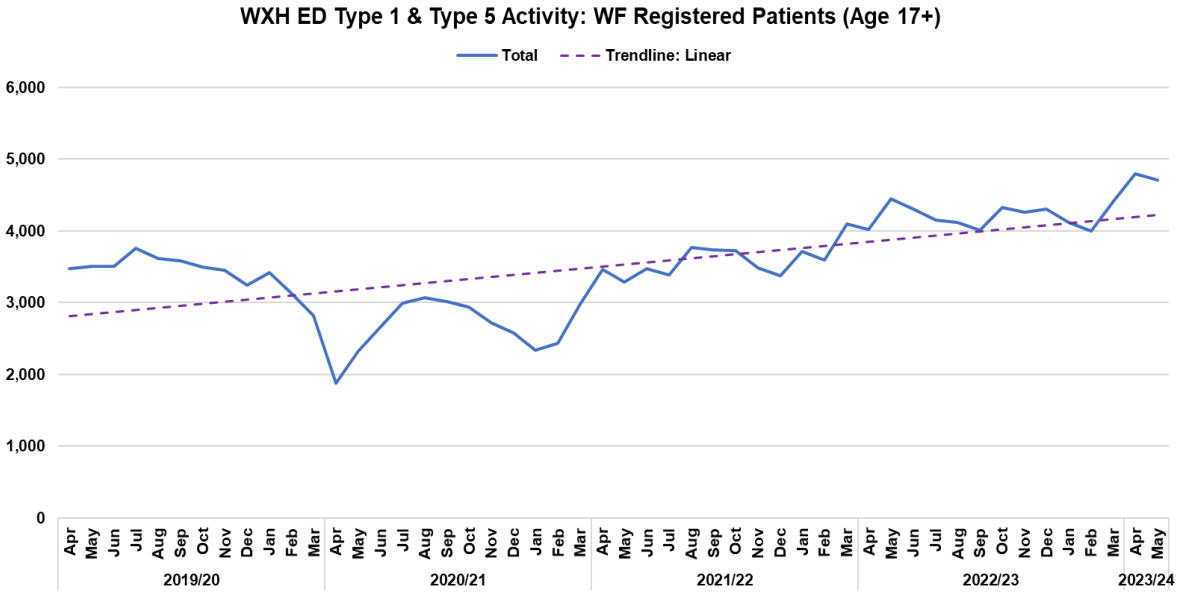
Figure 1: Reporting cycle



Front Door Activity Trend



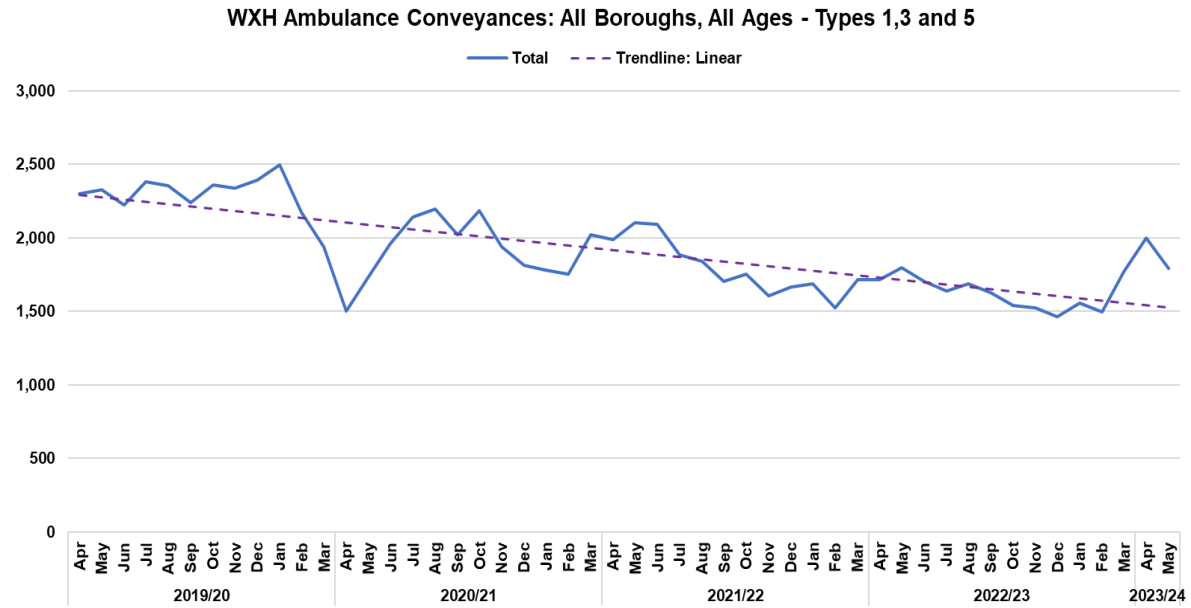


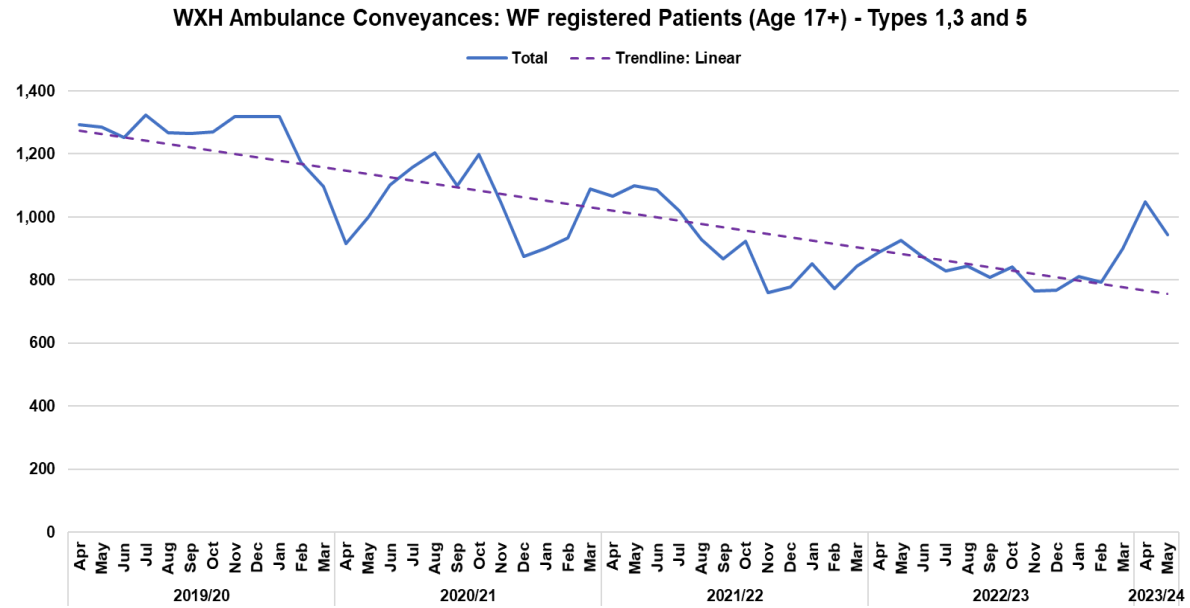


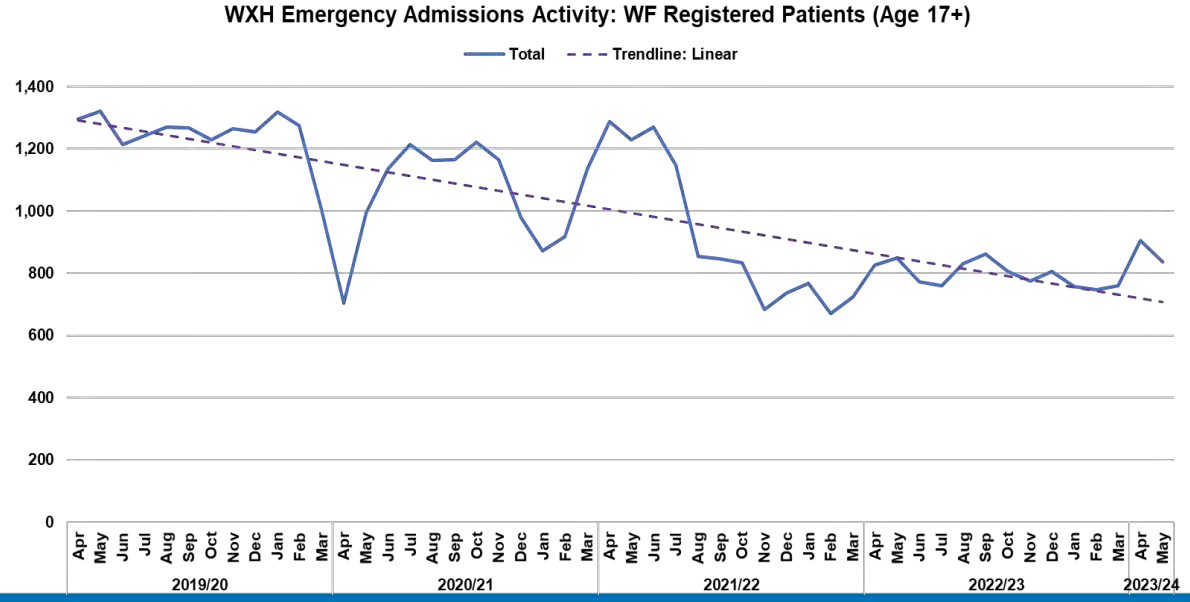
- Front door activity for all patients at the Whipps Cross Hospital is showing a linear increase in activity from the 2019/20 baseline.
- ED (Type 1) activity at the Whipps Cross Hospital for Waltham Forest registered patients (age 17+) is showing a slight linear increase in activity from the 2019/20 baseline.
- Whipps Cross Hospital ED (Type 1) and Ambulatory Care / SDEC (Type 5) activity for Waltham Forest registered patients (age 17+) is showing a linear increase in activity from the 2019/20 baseline.

Data Source: ECDS

ED Conveyances and Emergency admissions Trend



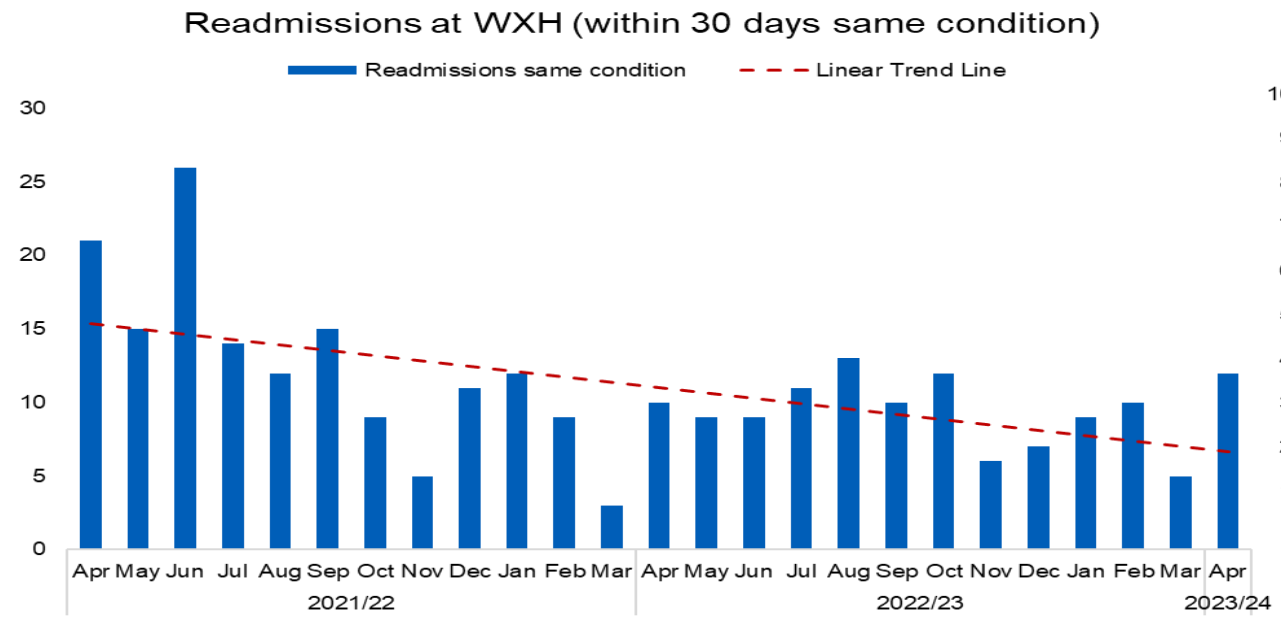


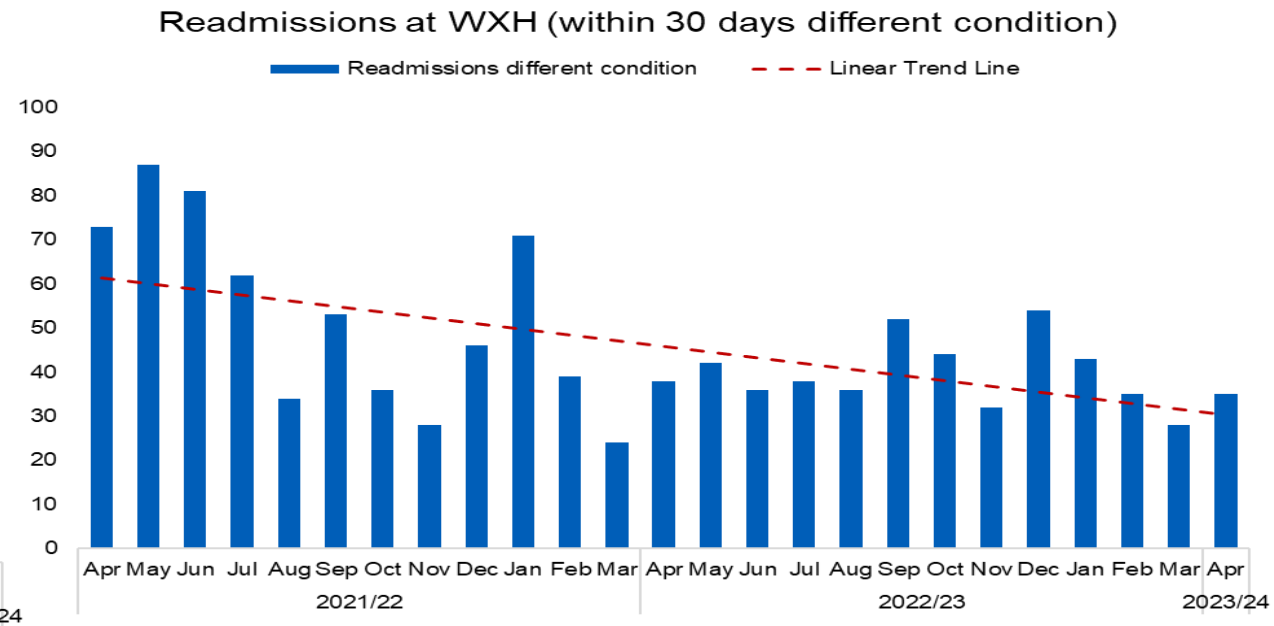


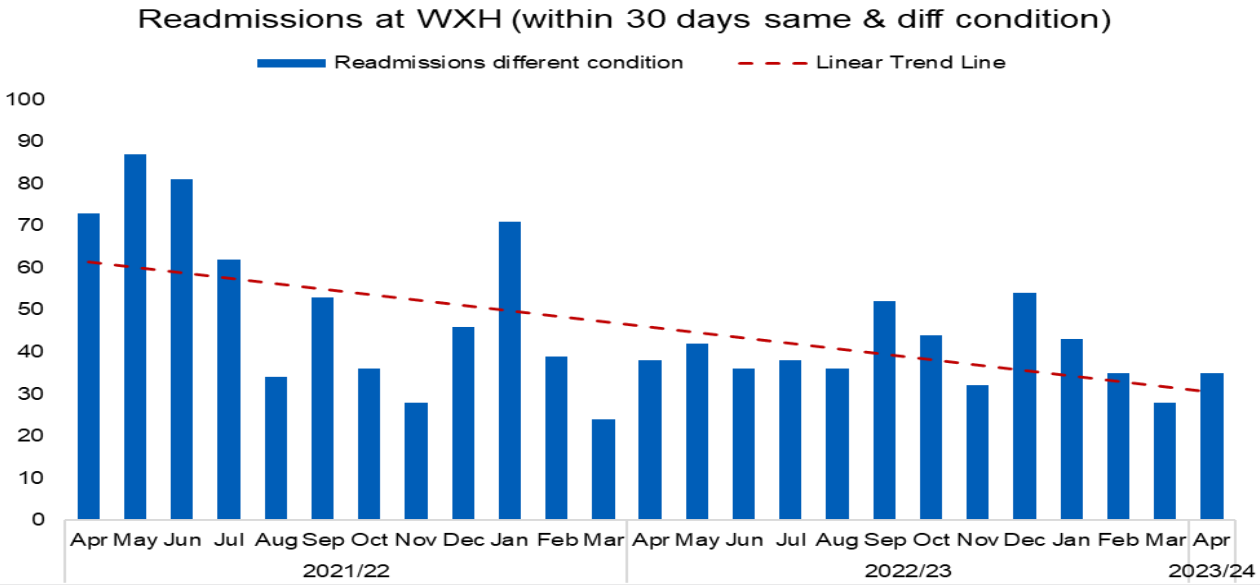
- Ambulance conveyances for all patients at the Whipps Cross Hospital shows a linear decrease in activity from the 2019/20 baseline.
- Ambulance conveyances at the Whipps Cross Hospital for Waltham Forest registered patients (age 17+) is showing a slight linear decrease in activity from the 2019/20 baseline.
- Whipps Cross Emergency Admissions activity for Waltham Forest registered patients (age 17+) shows a linear decrease in activity from the 2019/20 baseline.

Data Source: ECDS

Readmissions Trend







Note: Readmissions within 0-1 day is excluded from this report.

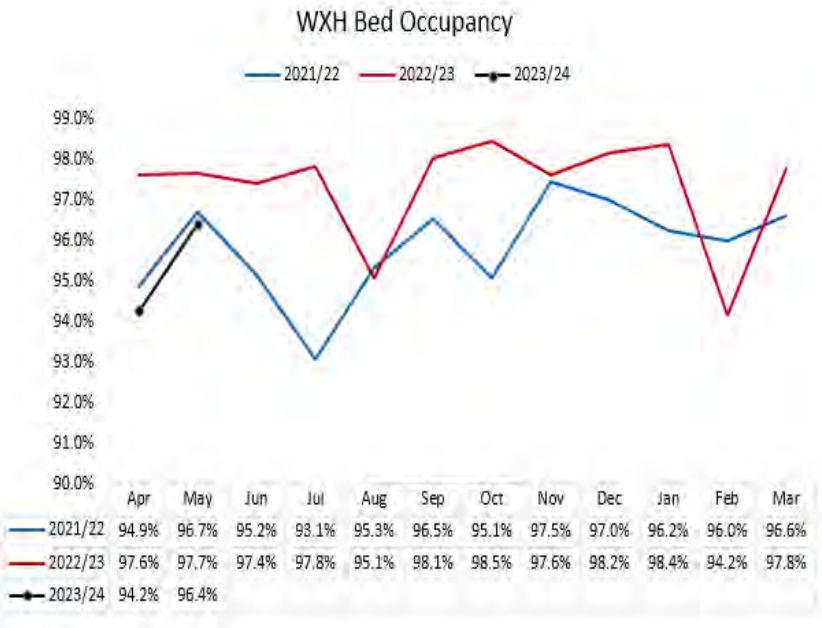
- Overall, readmissions in the period April 2021/22 to April 2023/24 (latest available data) shows a linear decrease. Readmissions within 30 days for the same condition in 2022/23 were about 19% lower than in 2021/22.

Other notes on the data:

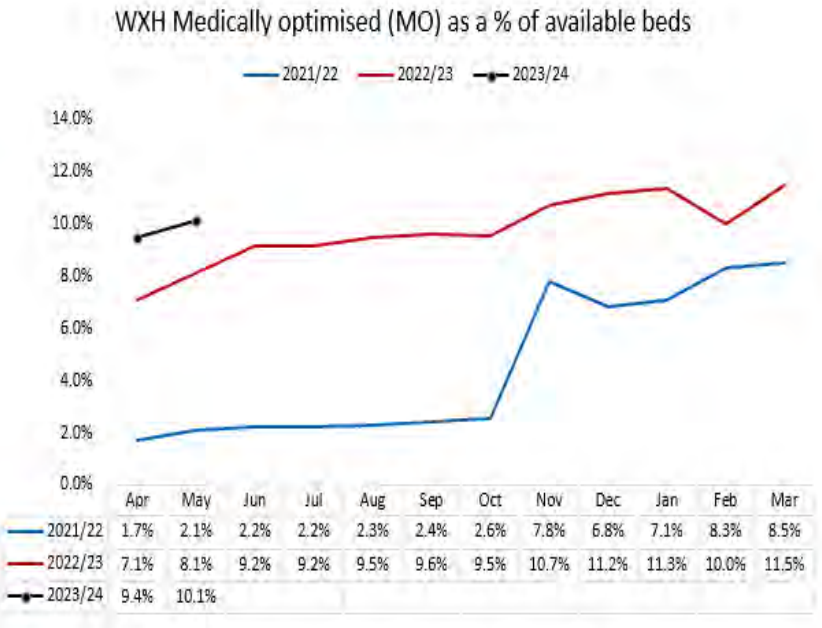
- *The data is for adults only (18 and above)*
- *Excludes cancer and maternity*

Data Source: SUS+

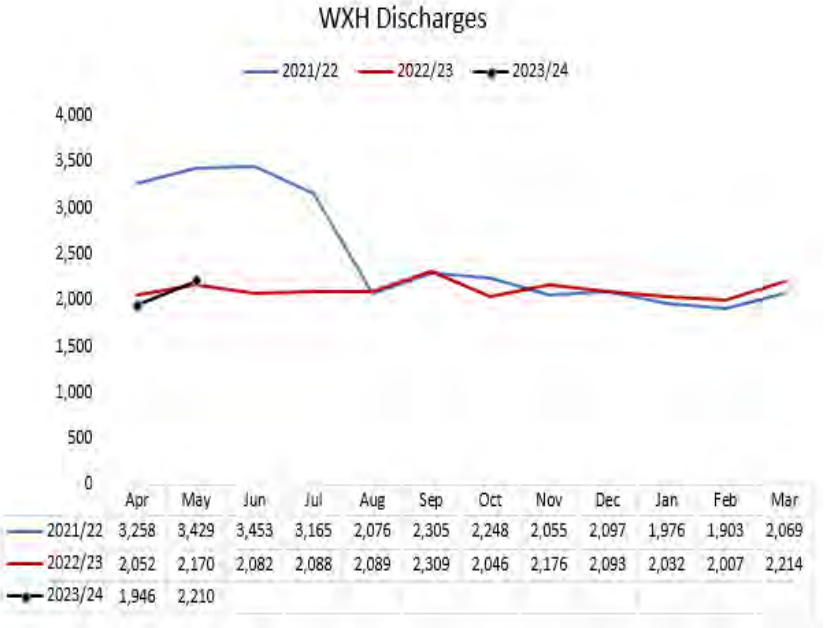
Bed Occupancy and Discharges Trend



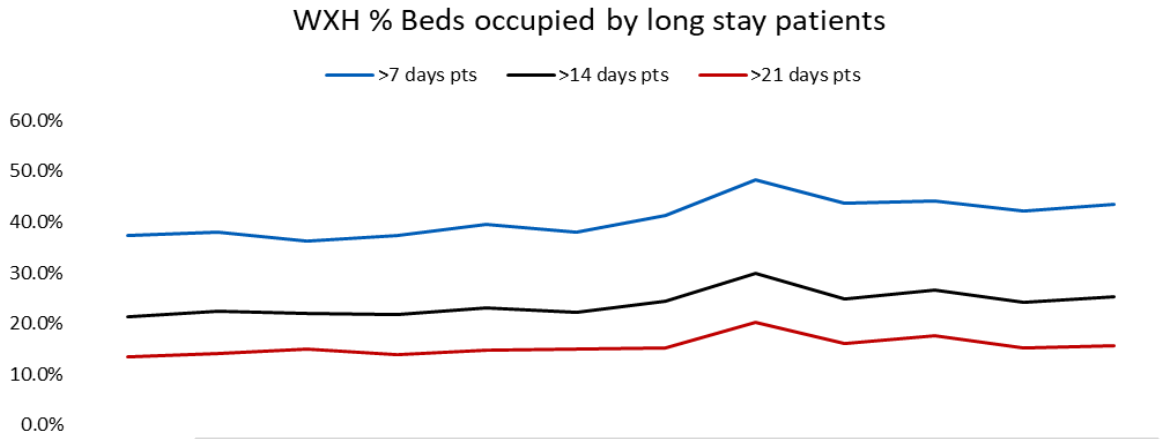
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	94.9%	96.7%	95.2%	93.1%	95.3%	96.5%	95.1%	97.5%	97.0%	96.2%	96.0%	96.6%
2022/23	97.6%	97.7%	97.4%	97.8%	95.1%	98.1%	98.5%	97.6%	98.2%	98.4%	94.2%	97.8%
2023/24	94.2%	96.4%										



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	1.7%	2.1%	2.2%	2.2%	2.3%	2.4%	2.6%	7.8%	6.8%	7.1%	8.3%	8.5%
2022/23	7.1%	8.1%	9.2%	9.2%	9.5%	9.6%	9.5%	10.7%	11.2%	11.3%	10.0%	11.5%
2023/24	9.4%	10.1%										



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	3,258	3,429	3,453	3,165	2,076	2,305	2,248	2,055	2,097	1,976	1,903	2,069
2022/23	2,052	2,170	2,082	2,088	2,089	2,309	2,046	2,176	2,093	2,032	2,007	2,214
2023/24	1,946	2,210										



	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
>7 days pts	37.4%	38.0%	36.2%	37.4%	39.6%	38.1%	41.2%	48.3%	43.7%	44.0%	42.2%	43.5%
>14 days pts	21.4%	22.5%	22.0%	21.9%	23.1%	22.3%	24.4%	29.9%	24.9%	26.6%	24.1%	25.2%
>21 days pts	13.4%	14.2%	15.0%	13.9%	14.7%	15.1%	15.3%	20.1%	16.1%	17.5%	15.1%	15.7%

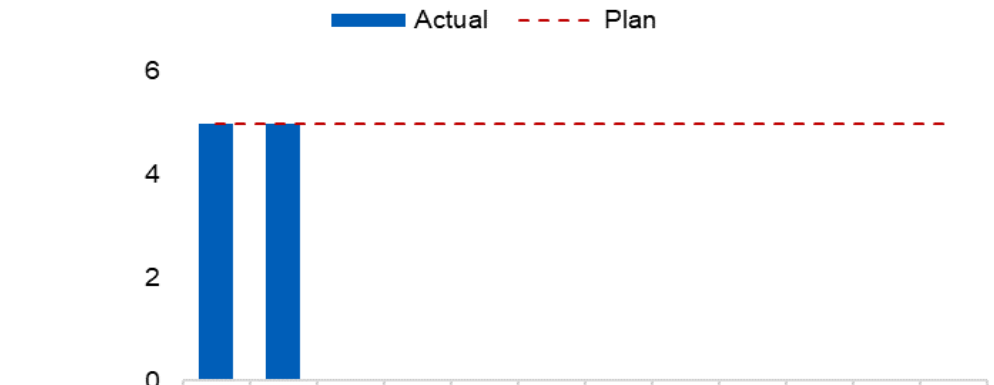
- Average bed occupancy went up to 96.4% in May compared to 94.2% in April. Bed occupancy has been above 95% in 10 out of the last 12 months.
- There is a significant increase in the proportion of medically optimised patients occupying available beds in 2022/23 compared to 2021/22. Latest data shows a 0.6% increase in May compared to April .
  (NOTE: DQ issues reported for of May – Sep 2021/22 data).
- The number of discharges from August 2022/23 has been relatively at similar levels to the same periods in 2021/22. May data shows a 14% increase in the number of discharges compared to April.
- Latest complete month's data shows an increase in the number of beds occupied by long stay patients, with 44% of beds occupied by patients with length of stay more than 7 days, 25% occupied by patients with length of stay more than 14 days and 16% occupied by patients with length of stay more than 21 days.

Data Source: Barts Bed Occupancy Report

CC2H: Care Homes MDT & Digital Remote Monitoring

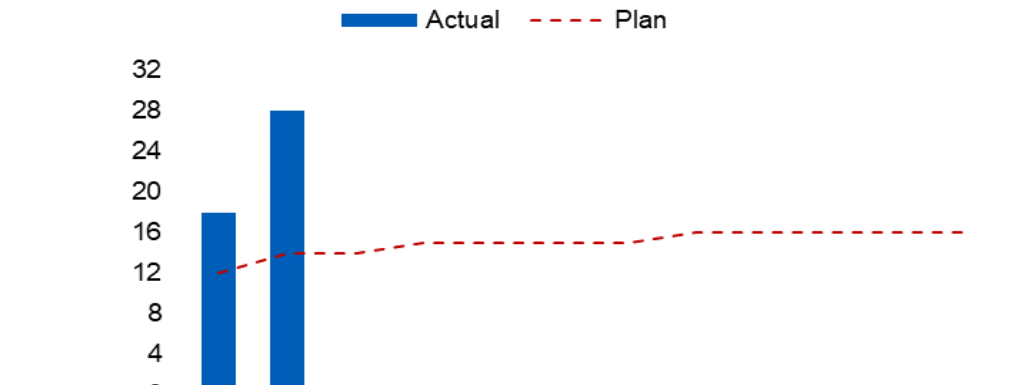
CARE HOMES MDT PERFORMANCE

Number of MDT meetings



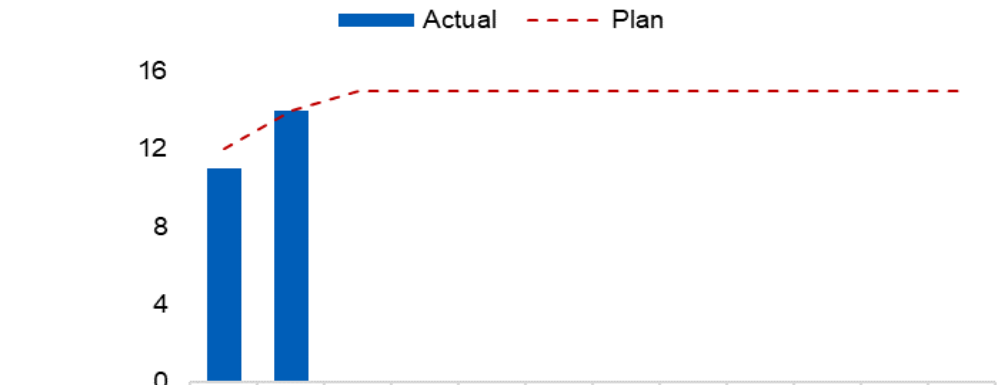
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	5	5										
Plan	5	5	5	5	5	5	5	5	5	5	5	5

Number of patients discussed



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	18	28										
Plan	12	14	14	15	15	15	15	16	16	16	16	16

Care homes having MDTs



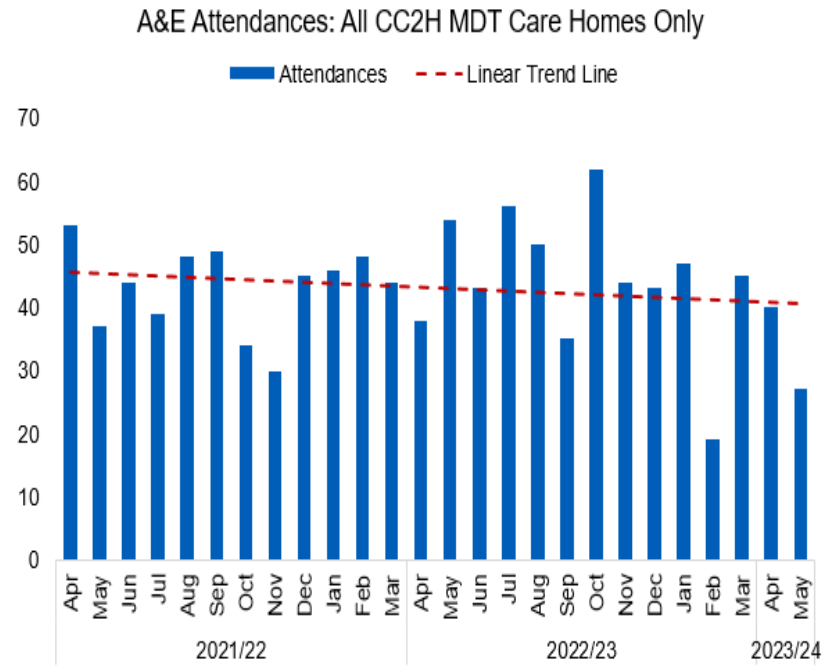
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	11	14										
Plan	12	14	15	15	15	15	15	15	15	15	15	15

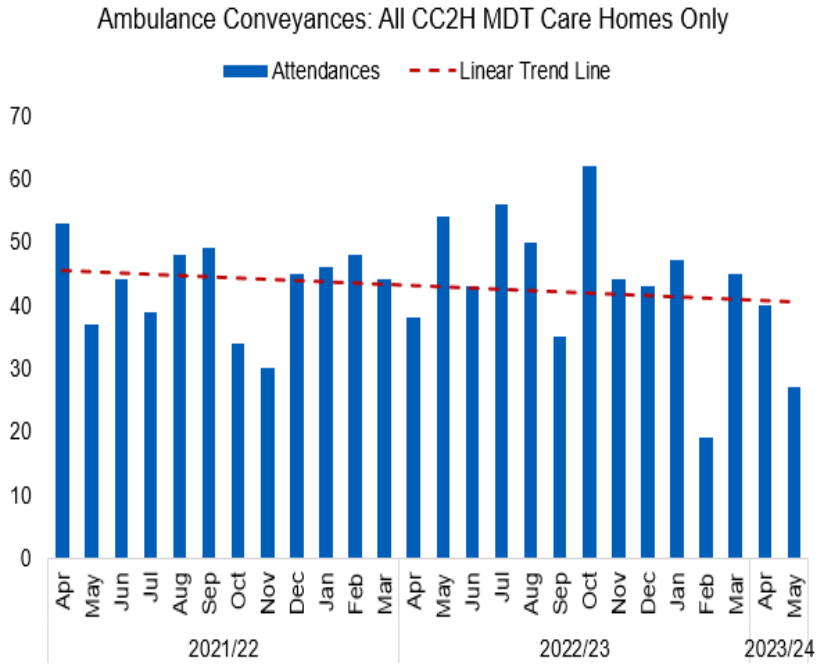
- The number of MDT meetings held are at the levels planned
- The number of patients discussed has been higher than planned, with the latest month's data showing a 100% increase over plan.
- There were 11 Care Homes that participated in the MDT in April (one less than planned). However, the latest month's data shows that the number of care homes having MDTs is at the level planned.

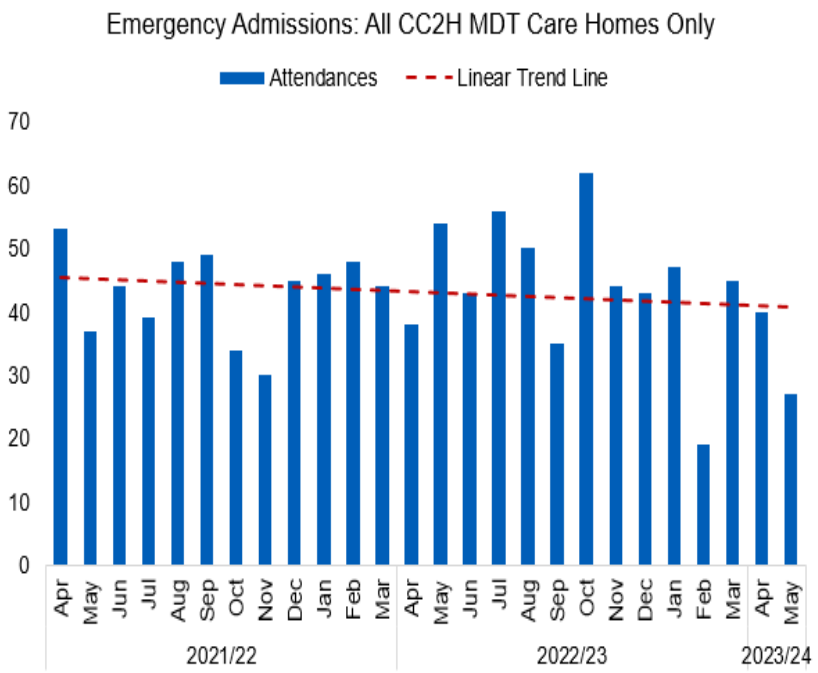
Note

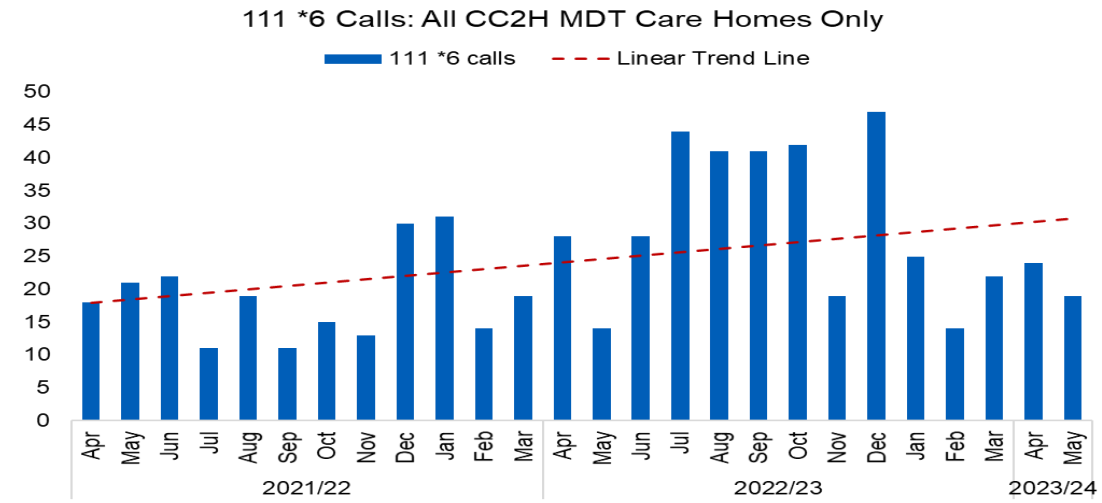
Not having a data sharing agreement in place is impacting on the ongoing evaluation work to demonstrate the impact of the Care Home MDTs on patients that have accessed the service.

CARE HOMES MDT IMPACT









Note:

1. *For illustrative purposes only. Too soon to attribute any hospital impact to the Care Homes MDT scheme.*
2. *Ambulance conveyances and A&E attendances exclude activity for Falls.*

- The The number of A&E attendances, ambulance conveyances and emergency admissions all show a linear decrease in activity from the 2021/22 financial year.
- The number of 111*6 calls shows a linear increase in activity from the 2021/22 financial year. More work may be needed to understand the reason/s for this trend.

Data Source
ECDS: A&E Attendances / Conveyances / Admissions

Data Sources
UEC Star Line Report : 111 *6

CARE HOMES CC2H MDT IMPACT

KEY: Roll-out dates | Sep-22 | Feb-23 | Mar-23 | Apr-23

CARE HOMES MDT IMPACT

A&E Attendances by CC2H MDT Care Homes

Care Homes	Beds	Bed Occ. 5/6/23	2021/22												2021/22 Total	2022/23												2022/23 Total	2023/24		2023/24 Total	Grand Total
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Apr	May		
Heathlands Care Home	63	83%	9	11	9	7	7	6	2	4		4	9	4	72	6	6	7	5	6	5	10	4	1	3	1	6	60	3	3	6	138
Albany Nursing Home	61	100%	4	3	4	4	2	3	5	3	6	6	6	6	52	4	5	3	10	7	8	6	7	5	6		5	66	4	1	5	123
George Mason Lodge	39	90%	5	3	8	3	9	7	7	3	6	6	7	8	72	3	9	3	7	3	3	2	5	2	4	2	1	44	4		4	120
Alliston House	42	95%	4	4	5	6	12	6	4	4	6	4	5	3	63	3	5	2	6	2	3	7	3	5	7	2	3	48	5	1	6	117
Aspray House	68	100%	4	2	3	3	4	4	3	5	1	3	8	7	47	6	5	3	4	7	2	3	4	5	3	2	2	46	4	4	8	101
St Ives Lodge Residential Care Home	35	100%	1	1	2	3		7	1	3	5	4	3	5	35	3	1	1	4	6	4	7	2	3	5	4	8	48	1	2	3	86
Spinney (the)	48	90%	6	1	2	1	5	4	1	2	5	3	4	1	35	2	2	4	5	2		3		2	2	2	6	30	2	3	5	70
Three Willows Residential Care Home	21	100%	5	3	3	2			2	1	2	3	1	2	24	1	5	8	2	4	4	10	3	5		1		43	1	2	3	70
St Francis Residential Care Home	39	80%	3	1	2	5	3	3	1	3	2	2	1	2	28		4	6	3	1		2	2	2	5	1	2	28	4	3	7	63
Parkview House Care Home	49	94%	2	2	3	1	1	1	3		1	3		2	19	4	4	4	4	2	3	5	4		4	2	1	37	3	4	7	63
Mapleton Road Home	24	92%	1	1	1	1		3		1	4	5	2	1	20	2		1	3	3	1	2	3	2	1	1	3	22	1	1	2	44
Highcroft Care Home	23	96%	2	1		2	2	2	1	1	3			2	16	1	1		3	4	2	4	1		3		2	21	3	1	4	41
St Catherine Rest Home	19	100%	4	1	1		1	3	1		2				13		1	1		2			4	4	3		2	17	1	2	3	33
Forest View Care Home	26	100%	1	2			1		1			1	1	1	8	2	6					1	2	6		1	3	21	2		2	31
Gracewell of Chingford (Ivy Grove)	46	87%	2	1	1	1	1		2		2	2	1		13	1				1				1	1		1	5	2		2	20
Grand Total			53	37	44	39	48	49	34	30	45	46	48	44	517	38	54	43	56	50	35	62	44	43	47	19	45	536	40	27	67	1120

Ambulance Conveyances by CC2H MDT Care Homes

Care Homes	Beds	Bed Occ. 5/6/23	2021/22												2021/22 Total	2022/23												2022/23 Total	2023/24		2023/24 Total	Grand Total
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Apr	May		
Heathlands Care Home	63	83%	7	10	8	7	7	5	2	4		4	7	1	62	6	5	6	5	6	5	9	4	1	3	1	6	57	3	3	6	125
Albany Nursing Home	61	100%	4	3	4	4	1	3	4	3	4	6	5	6	47	3	4	3	10	7	6	6	6	5	6		4	60	4	1	5	112
George Mason Lodge	39	90%	5	3	8	3	9	7	7	3	5	6	5	6	67	2	7	3	6	3	2	2	5	2	4	2	1	39	4		4	110
Alliston House	42	95%	2	3	4	6	11	6	4	4	5	3	5	3	56	3	5	2	6	2	3	7	3	5	6	1	3	46	5	1	6	108
Aspray House	68	100%	2	2	3	3	4	4	3	5	1	3	8	7	45	6	5	3	2	5	2	3	4	5		2	2	39	4	4	8	92
St Ives Lodge Residential Care Home	35	100%	1	1	1	2		7	1	3	3	4	2	4	29	3	1	1	3	6	4	6		3	4	3	8	42	1	2	3	74
Three Willows Residential Care Home	21	100%	4	3	3	2			2	1	2	3	1	2	23	1	5	8	2	4	3	10	3	5		1		42	1	2	3	68
St Francis Residential Care Home	39	80%	3	1	2	5	3	3	1	3	1	2	1	2	27		4	5	3	1		2	2	1	5	1	2	26	4	3	7	60
Spinney (the)	48	90%	6	1	2	1	5	2	1	2	5	3	3	1	32	2	2	2	5	2		3		1	2	1	3	23	2	3	5	60
Parkview House Care Home	49	94%	2	2	2	1	1	1	1		1	3		1	15	4	3	4	2	2	3	5	4		3	2	1	33	2	3	5	53
Mapleton Road Home	24	92%			1	1		3		1	4	5	2	1	18	2		1	3	2	1	2	2	1		1	1	16	1	1	2	36
Highcroft Care Home	23	96%	2	1		2	2	2		1	3			2	15	1	1		1	3	2	3	1		2		1	15	3	1	4	34
Forest View Care Home	26	100%	1	2			1		1			1	1	1	8	2	5					1	2	6		1	2	19	2		2	29
St Catherine Rest Home	19	100%	4	1	1		1	2	1		1				11		1	1		2			1	3	1		2	11	1	1	2	24
Gracewell of Chingford (Ivy Grove)	46	87%	2		1	1			2		2	2	1		11	1				1				1	1		1	5	2		2	18
Grand Total			45	33	40	38	45	45	30	30	37	45	41	37	466	36	48	39	48	46	31	59	37	39	37	16	37	473	39	25	64	1003

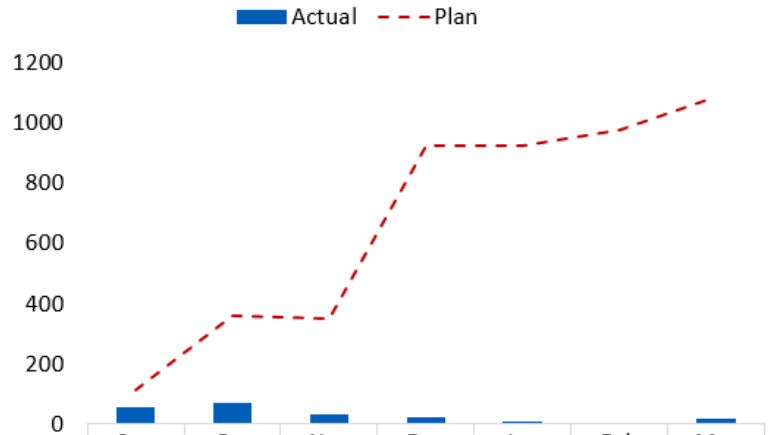
Data Source
ECDS: A&E Attendance and Conveyances

Data Source
Capacity Tracker: Beds & Occupancy

Care homes digital remote monitoring

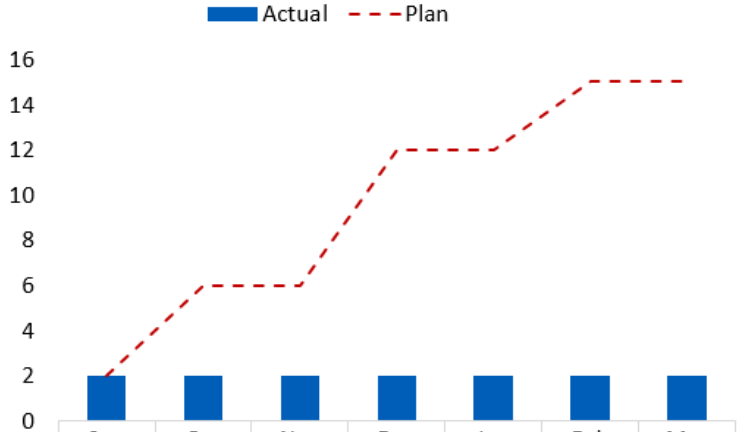
DIGITAL REMOTE MONITORING PERFORMANCE

Digital hub activity: Number of calls



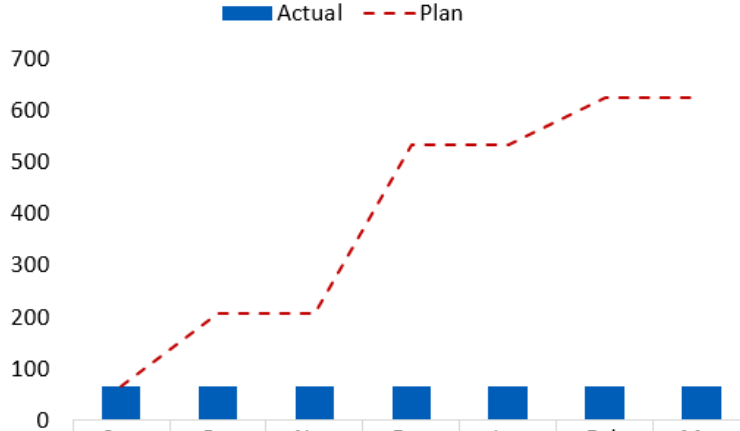
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	53	69	31	20	5	0	16
Plan	111	358	346	924	924	977	1082

Care homes accessing digital hub



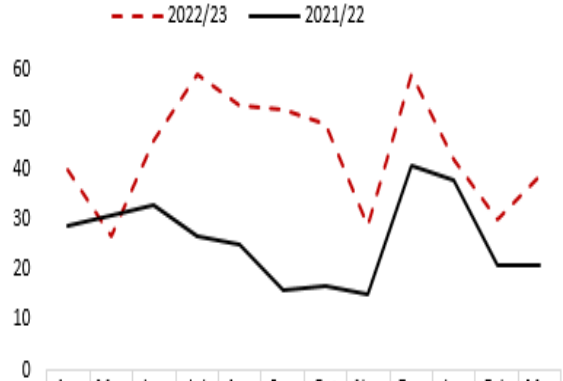
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	2	2	2	2	2	2	2
Plan	2	6	6	12	12	15	15

Care homes accessing digital hub: bed capacity



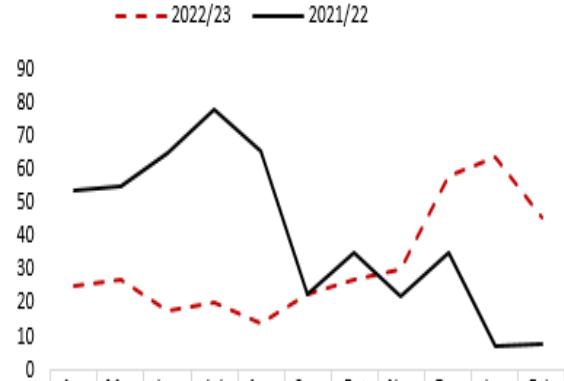
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	66	66	66	66	66	66	66
Plan	66	206	206	532	532	623	623

111 *6 calls from Care Homes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	40	27	46	59	53	52	49	29	59	42	30	39
2021/22	29	31	33	27	25	16	17	15	41	38	21	21

Calls to rapid response from care homes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2022/23	25	27	18	20	14	23	27	30	58	64	46
2021/22	54	55	65	78	66	23	35	22	35	7	8

Note: Improved data quality has meant that the Digital Hub plan and actual activity data presented in the last report has had to be reviewed. The numbers in this report are therefore different from those reported in the last report.

- Number of calls: target developed from average calls received between 30 August – 31 October and applied pro-rata for each month. Scaling up care home access to the Digital Hub remote monitoring service has been a challenge particularly owing to the availability of care home staff to receive training which is a requirement prior to the onboarding process.
- 111*6 calls: this metric is included for illustration purposes at present, and includes data for all care and nursing homes in Waltham Forest. The Digital Hub is currently available to two care homes, and will focus only on older adult residential care homes in year one (to March 23).
- Rapid Response calls: Some level of reduction is expected to be seen in the number of calls to Rapid Response once the Digital Hub service is fully embedded. Of particular note however, is that the Rapid Response dataset now includes a Digital Hub identifier so that any calls received from the hub will be identifiable and therefore the quantity of calls and quality of the clinical handover can both be assessed.

NOTE: No Digital Hub activity data to report in Feb 2022/23

Home First Performance, Impact & Quality

Rapid Response – Business Case Planning Assumptions

Data for 2021 was used as a baseline and the modelling was based on forecast demand, capacity and impact of Rapid Response. There were 3 key assumptions:

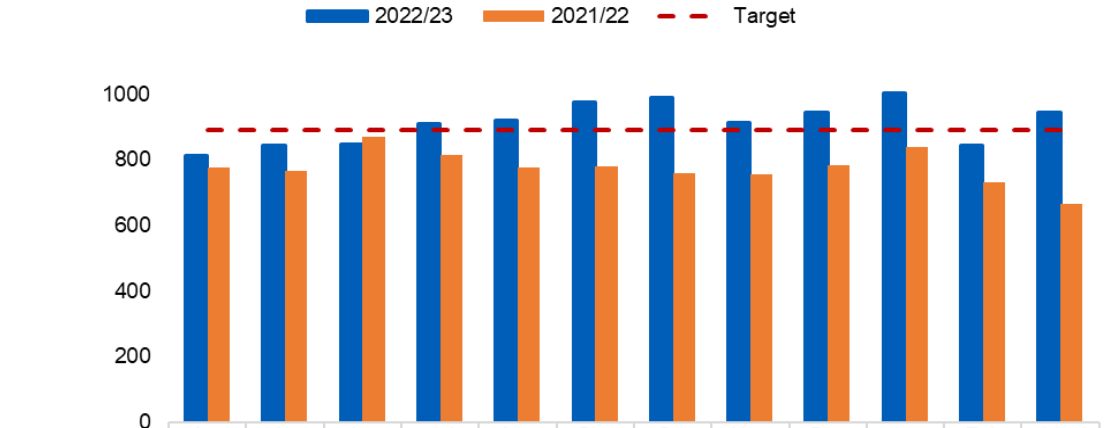
1. **Activity levels -** Rapid Response activity levels (referrals) in 2022 would increase by 10% over the baseline, leading to 10,750 referrals in 2022 (an average of 892 referrals per month - referred to as target) and an increase by 20% in 2023, leading to 11,678 referrals (an average of 973 referrals per month – referred to as target). Activity levels by 2024 would peak at 12,652 per annum.

2. **Reduction in non-elective admissions and bed days –** The increase in staff over the next 3 years, coupled with implementation of a new Admission Avoidance model, scaling up of the virtual ward to accept admission avoidance, a new personal social care service able to deliver more hours of care and support short-term immediate need to avoid admission (with additional transformation funding of £263k cumulative by 2024/25) as well as enhancing out of hours medical input would reduce admissions by 40%. In 2022 this would result in 1.067 admissions avoided per day and in 2023, 2.133 admissions avoided per day. By 2024 admissions avoided would peak at 3.2 admissions per day.

3. **Workforce requirements –** to meet the increased demand an additional 5.9 WTE staff would be needed in 2022/23, rising to an additional 11.7 WTE (cumulative) in 2023/24 and 17.6 WTE (cumulative) in 2024/25.

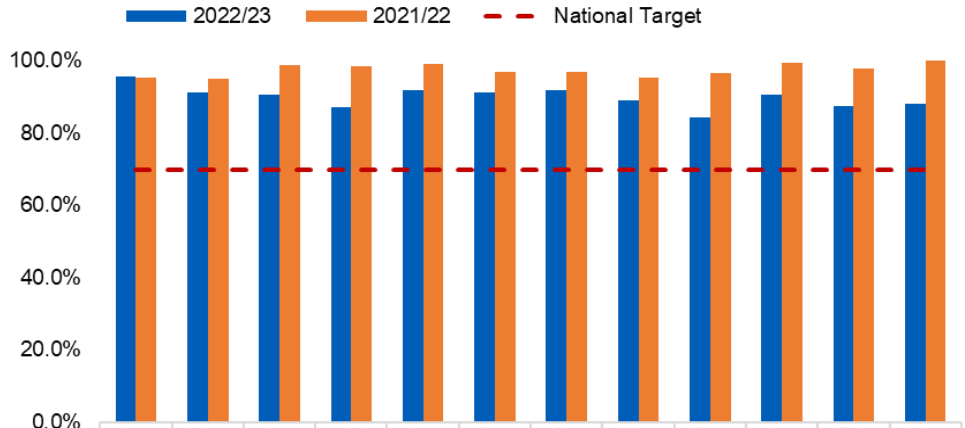
RAPID RESPONSE PERFORMANCE

Number of Rapid Response referrals



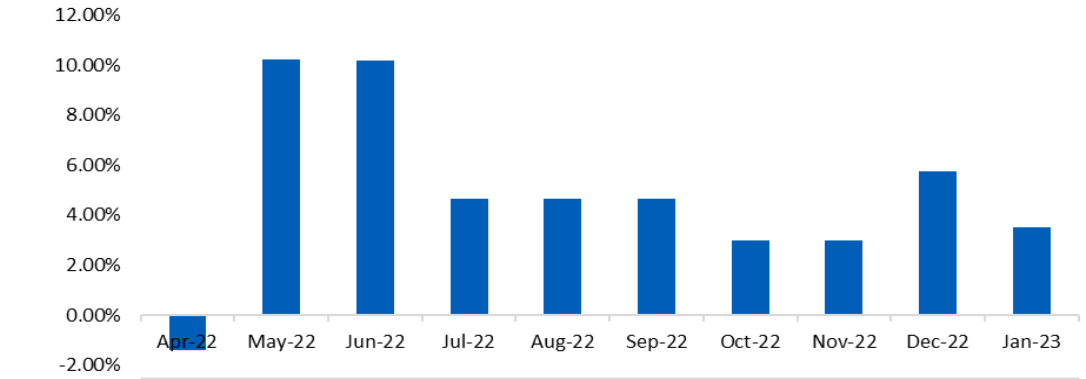
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	814	844	847	911	922	977	990	914	943	1005	844	944
2021/22	775	766	869	815	778	780	758	755	785	840	733	667
Target	892	892	892	892	892	892	892	892	892	892	892	892

% of Urgent referrals responded to within 2 hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	95.8%	91.3%	90.6%	87.3%	92.0%	91.3%	91.8%	89.0%	84.5%	90.7%	87.6%	88.2%
2021/22	95.5%	95.0%	98.9%	98.5%	99.2%	96.8%	96.9%	95.3%	96.6%	99.4%	97.9%	100.0%
National Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%

Rapid Response staff vacancy rate

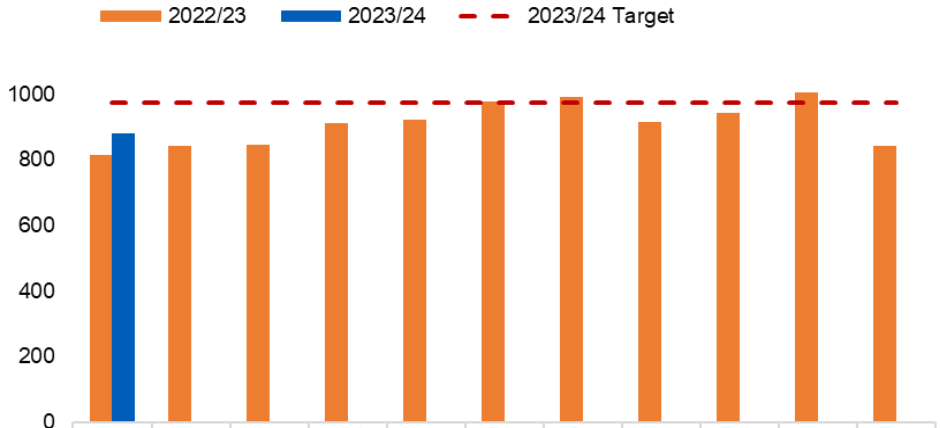


	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Vacancy rate	-1.41%	10.25%	10.20%	4.65%	4.65%	4.65%	3.00%	3.00%	5.76%	3.53%

- It was forecast that Rapid Response Referrals would rise in 2022/23 to an average of 892 referrals per month. Since July 2022 they have exceeded the target number of referrals, but in February 2023 there was a slight drop below target.
- It was estimated in the business case that in 2022/23 activity levels would reach 10,750 for the year. The outturn was 10,955. The assumptions made in the business case are correct.
- The national target for the % of urgent referrals to rapid response to be undertaken within 2 hours is 70%. Rapid Response continues to perform strongly in this area and on average 96% of urgent referrals are responded to within 2 hours..
- During 2022/23 transformation monies were used to expand the permanent number of Rapid Response staff. Overall across 2022/23 the vacancy rate has reduced.

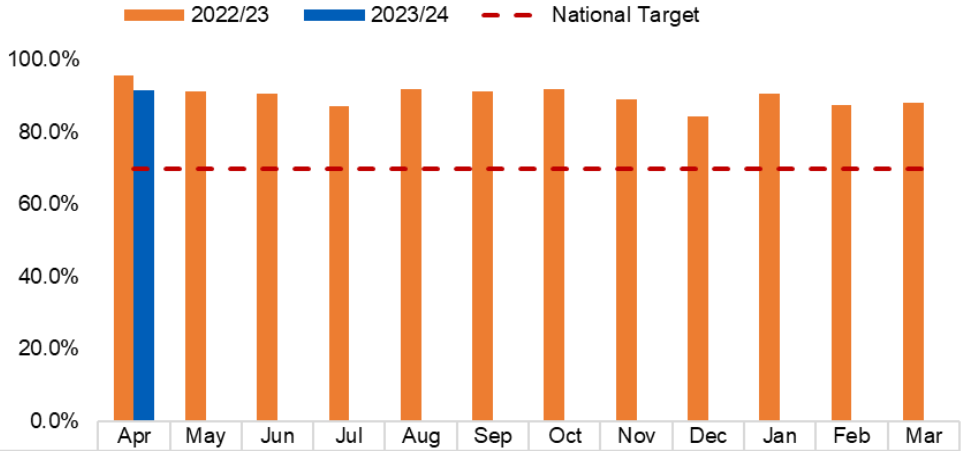
RAPID RESPONSE PERFORMANCE

Number of Rapid Response referrals



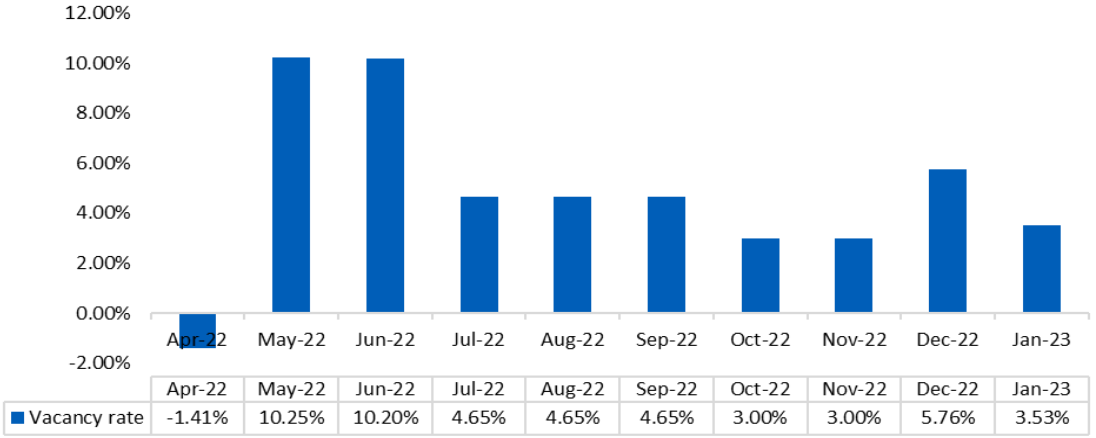
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2022/23	814	844	847	911	922	977	990	914	943	1005	844
2023/24	882										
2023/24 Target	973	973	973	973	973	973	973	973	973	973	973

% of Urgent referrals responded to within 2 hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	95.8%	91.3%	90.6%	87.3%	92.0%	91.3%	91.8%	89.0%	84.5%	90.7%	87.6%	88.2%
2023/24	91.5%											
National Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%

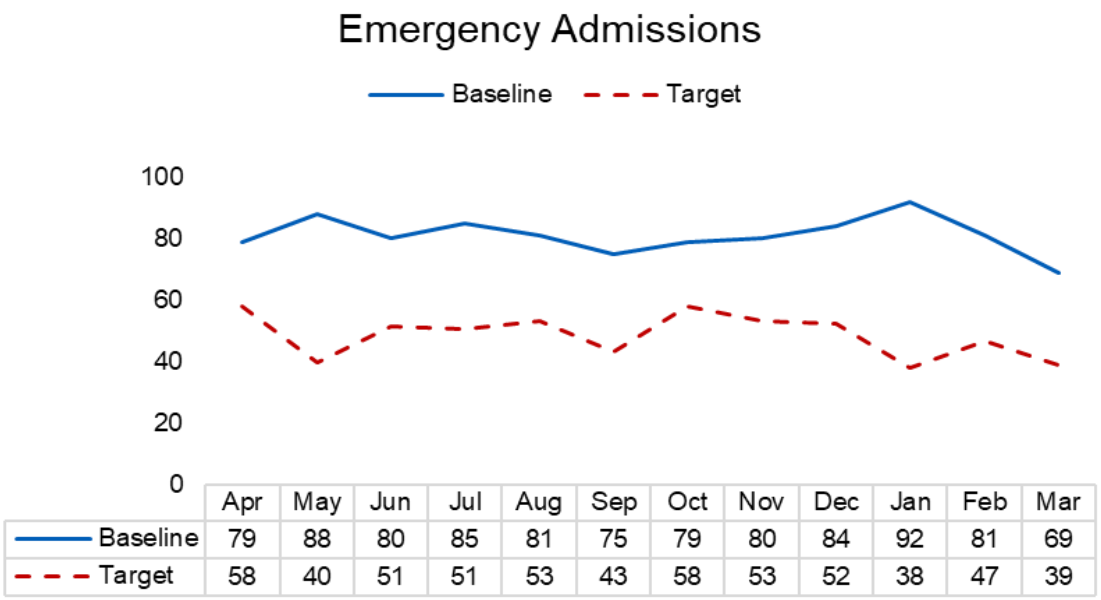
Rapid Response staff vacancy rate



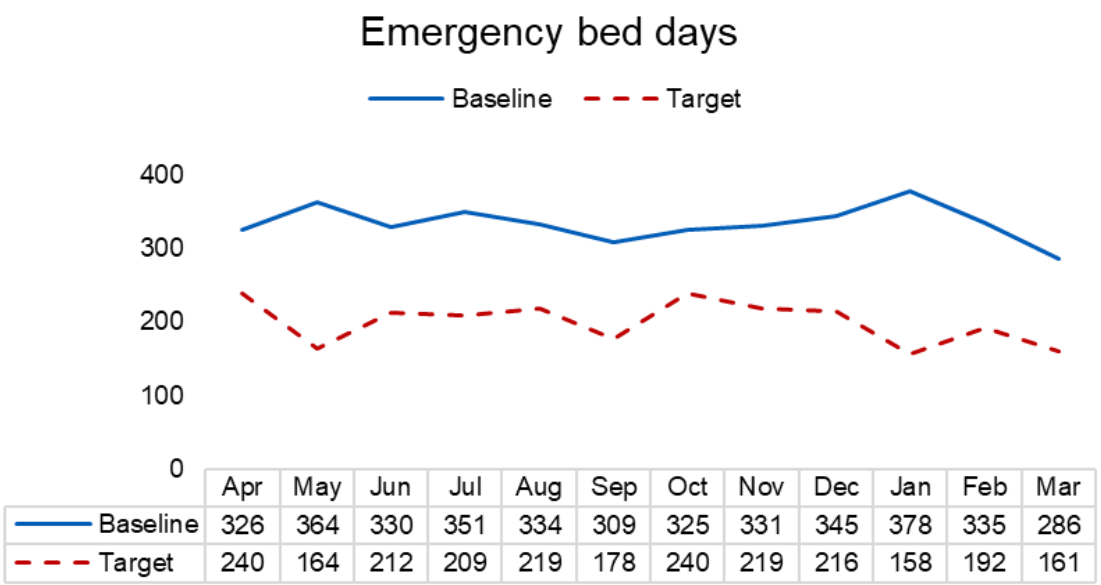
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Vacancy rate	-1.41%	10.25%	10.20%	4.65%	4.65%	4.65%	3.00%	3.00%	5.76%	3.53%

- It was forecast that Rapid Response Referrals would rise in 2023/24 to an average of 973 referrals per month. The figure for April shows an increase over the same period in 2022/23 and a -9% variance to the target.
- The national target for the % of urgent referrals to rapid response to be undertaken within 2 hours is 70%. Rapid Response continues to perform strongly in this area with the April figure showing that 92% of urgent referrals were responded to within 2 hours.
- During 2022/23 transformation monies were used to expand the permanent number of Rapid Response staff. Overall across 2022/23 the vacancy rate has reduced.

Rapid Response expansion impact: Business Case Planning Assumptions



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	79	88	80	85	81	75	79	80	84	92	81	69
Target	58	40	51	51	53	43	58	53	52	38	47	39



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	326	364	330	351	334	309	325	331	345	378	335	286
Target	240	164	212	209	219	178	240	219	216	158	192	161

The business case assumed a 40% decrease in admissions and a corresponding decrease in emergency bed days over the 2021/22 baseline. We have not yet been able to determine if the assumption is true.
In order to validate the assumption, further work will be required to understand the modelling in the context of an overall decrease in admissions and bed days at WXH and to carry out an evaluation on a number of patient records to see if there has been a decrease in admissions (and bed days) and an increase in utilisation of other community services.

Note: Admissions avoidance and bed days targets are based on modelling assumptions in the business case on the number of admissions expected to be avoided and bed days saved as a result of increased RR capacity

Rapid Response – Friends and Family Test (April 2023)

Yes (Current Month)
76.5%

Yes	No
26	8

Yes (Current Month)
82.4%

Yes	No
14	3

Yes/Yes, sometimes (Current Month)
100.0%

Yes	No
17	0

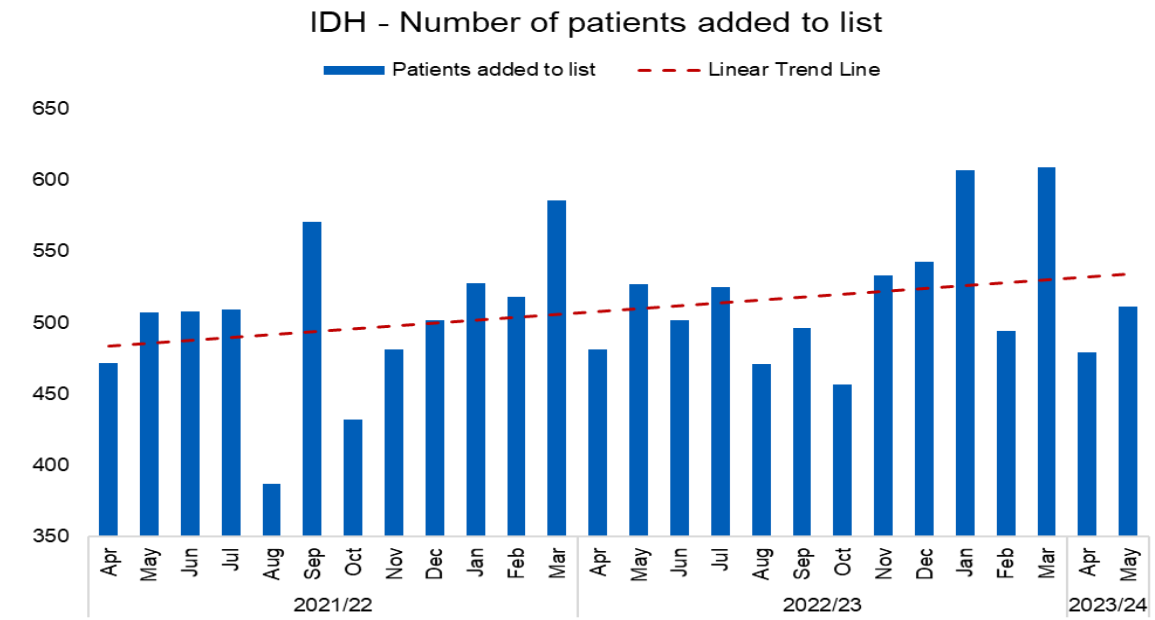
Yes/Yes, sometimes (Current Month)
88.2%

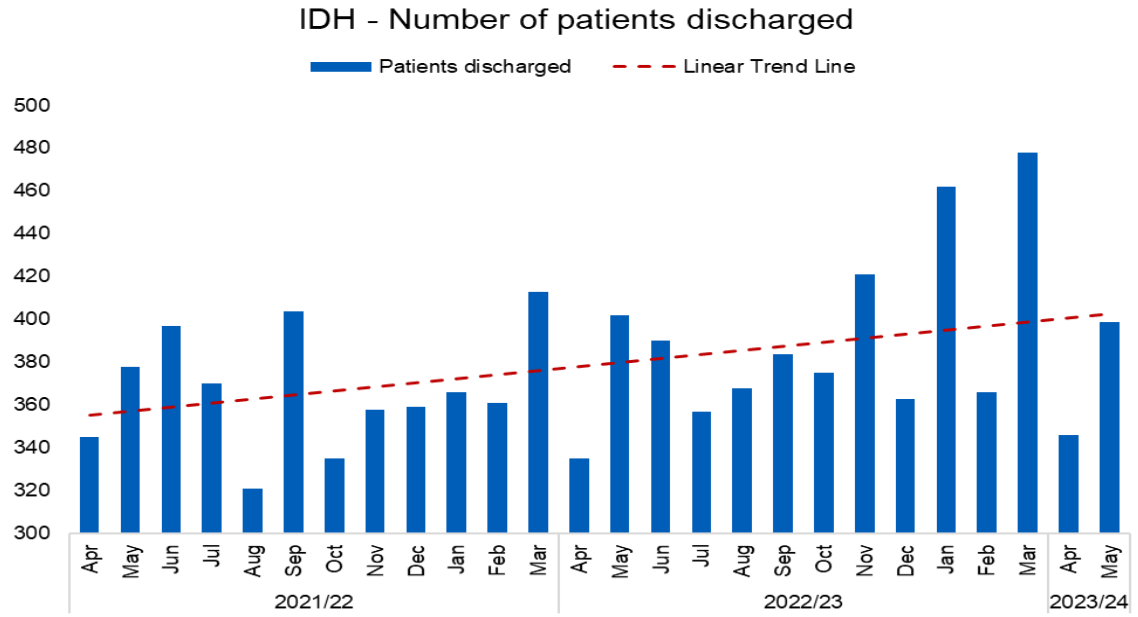
Yes	No
15	2

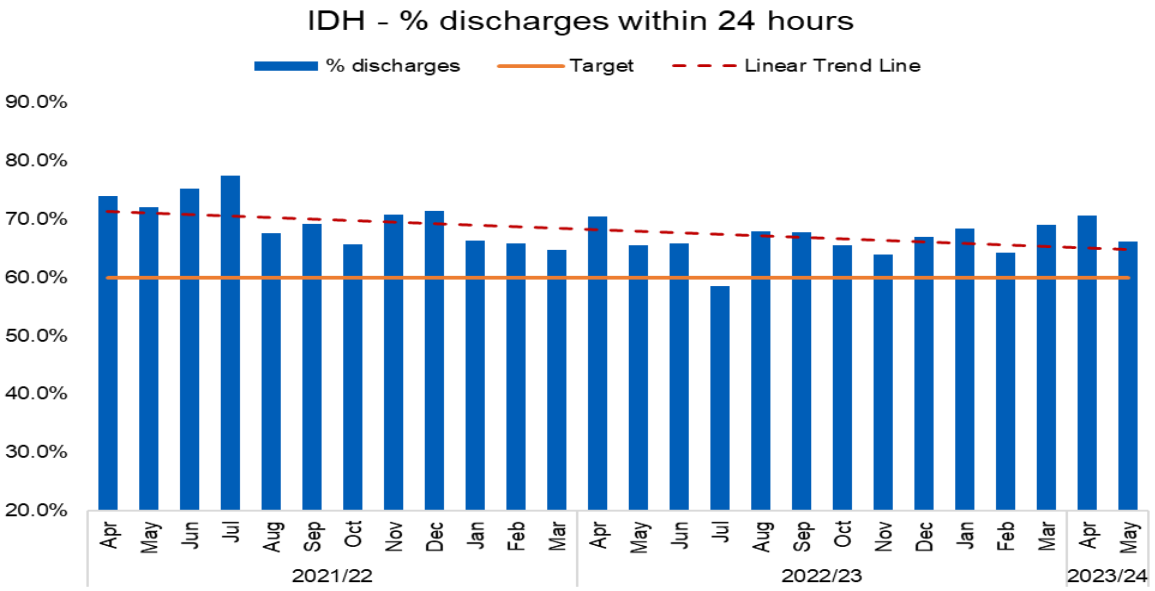
Yes/Yes, sometimes (Current Month)
82.4%

Yes	No
14	3

- In April 2023, 76.5% of respondents to the Rapid Response FFT survey confirmed that overall, they had a good or very good experience when they accessed the Rapid Response service.
- 82.4% of the respondents to the survey also confirmed that they found it easy to access care, treatment or support at the service.
- The proportion of respondents who confirmed that the service met their expectations and felt that they were involved in the care they received stood at 82.4% and 88.2% respectively.

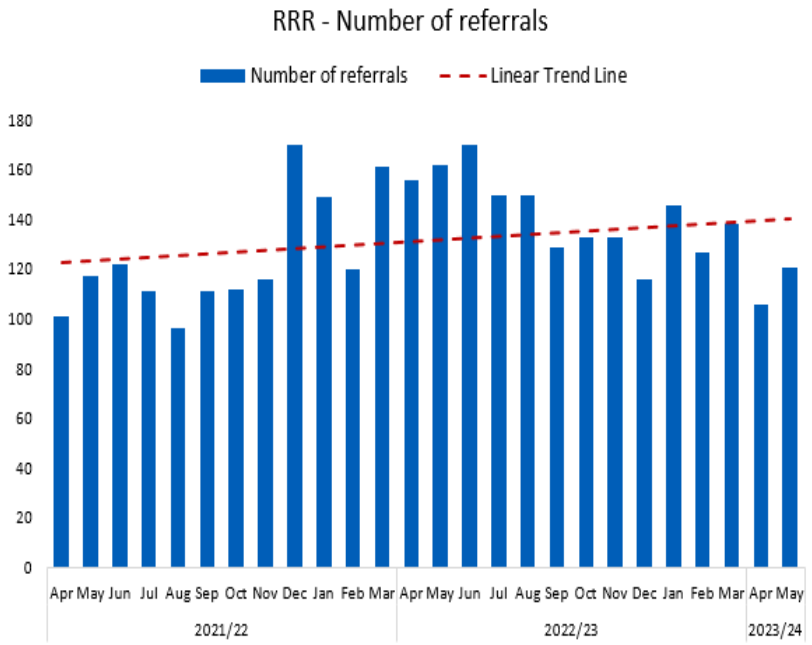


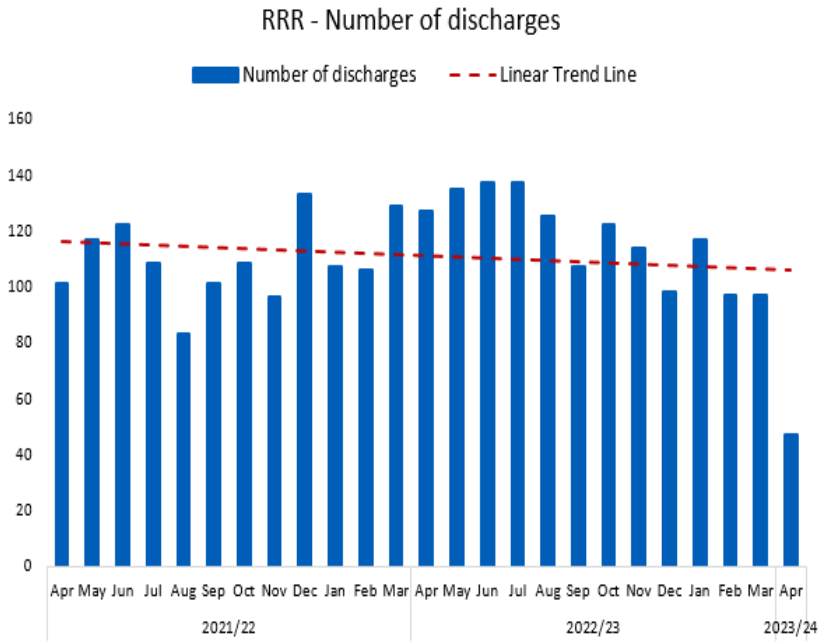


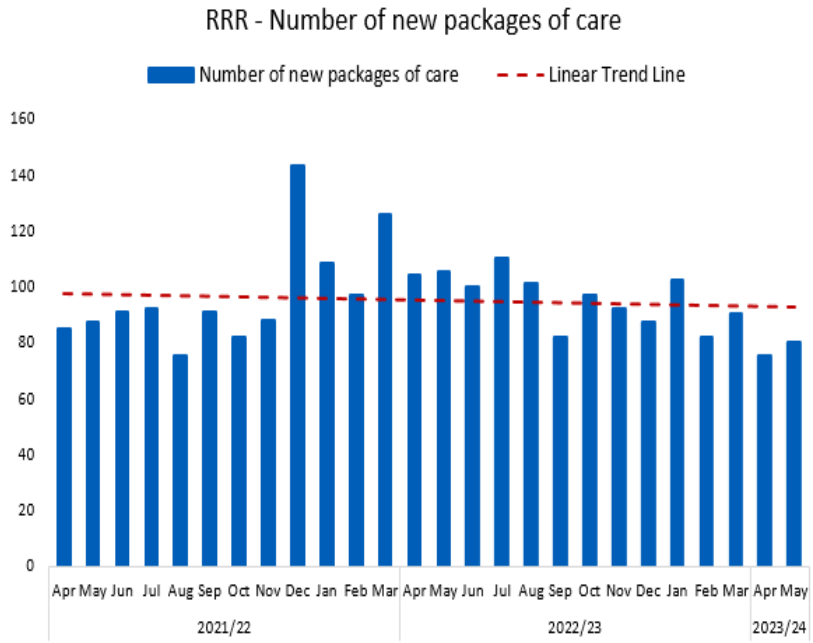


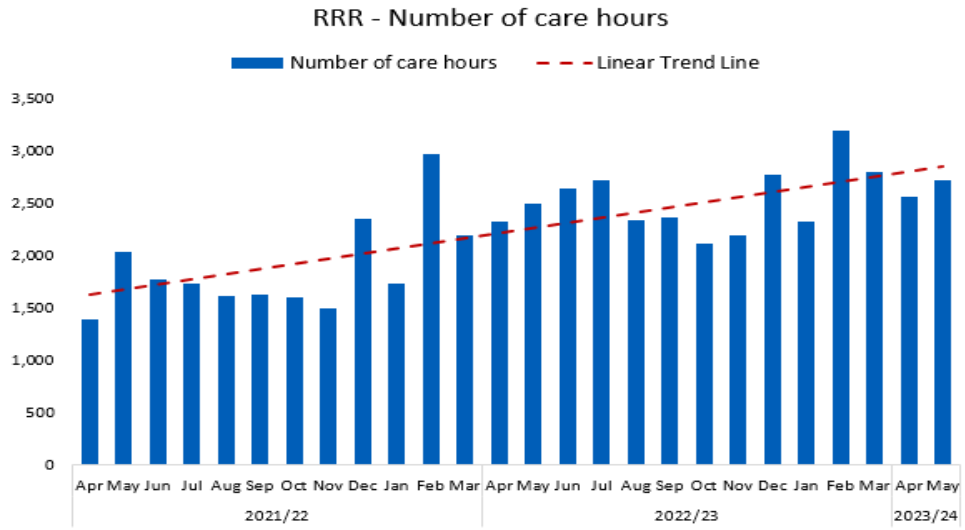
- The number of patients added to the list shows a linear increase in activity from the 2021/22 baseline.
- The number of patients discharged per month remains high and also shows a linear increase in discharges from the 2021/22 baseline.
- There has been an overall drop of 6% in same day discharges between April 2021/22 and May 2023/24 . Additional work will be undertaken to determine the reasons for this, although early indications from recent work undertaken by Newton Europe around the D2A offer suggests there has been capacity issues in some areas of sourcing packages of care.
- During 2021/22 an average of 262 discharges per month took place same day. In 2022/23 on average 241 discharges per month take place same day. Month on month discharges within 24 hours exceed the 60% target..

REHAB, REABLEMENT AND RECOVERY PERFORMANCE



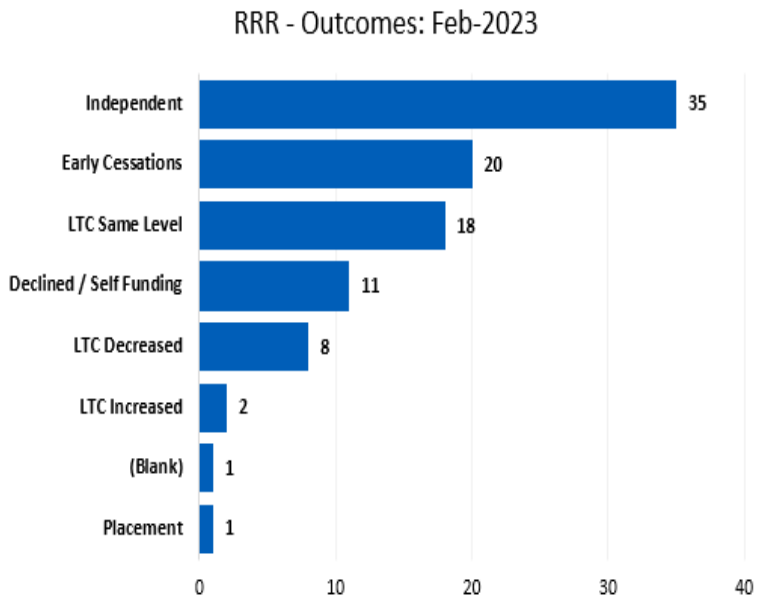


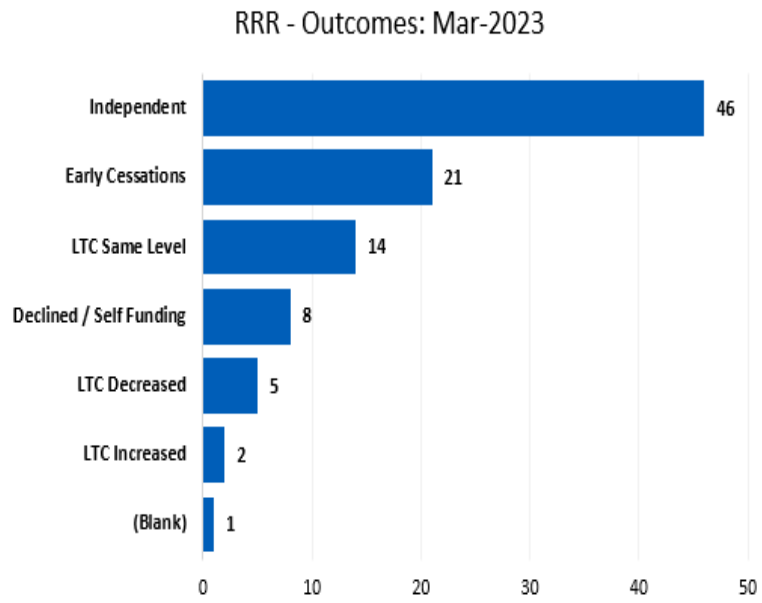


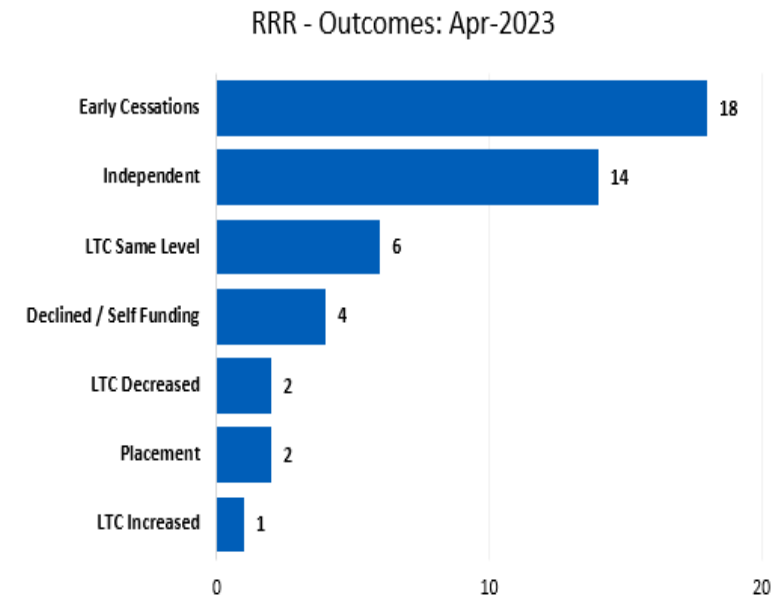


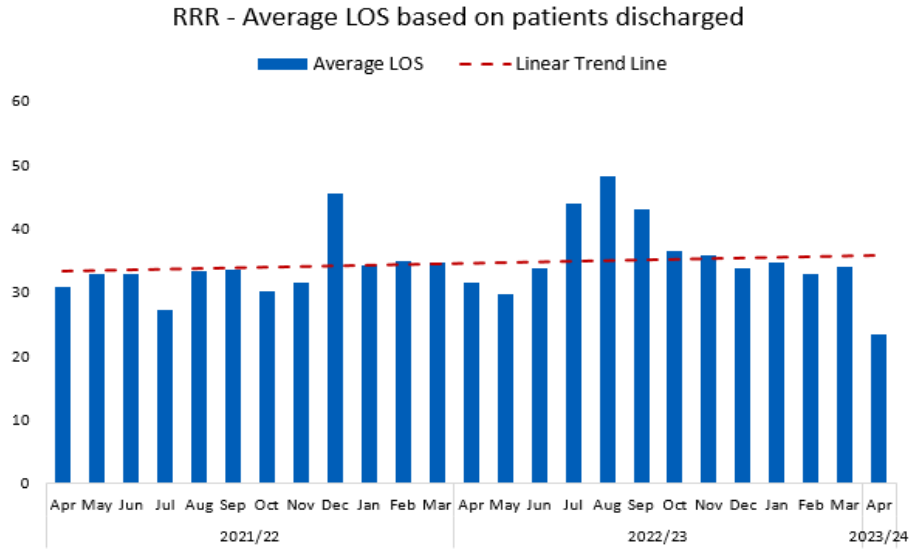
- There has been a significant increase in the number of referrals per month into rehabilitation and reablement,. In 2021/22 the monthly average was 124 in 2022/23 the monthly average is 143, an increase on average of 19 more referrals per month.
- The number of people being discharged from rehabilitation and reablement (cases closed) was initially higher in 2022/23 than in 2021/22 in line with the increased level of referrals. Further work is needed to analyse the data (discharges) in Q4. Some people have remained with the service longer than 6 weeks due to the therapy waiting list..
- On average throughout 2022/23 there has been an additional 6 new packages a month compared to the average in 2021/22 – the difference between referral levels and new packages started per month is accounted for by inappropriate referrals.
- On average an additional 774 hours per month of care and support are being delivered in 2022/23 as opposed to 2021/22.- approximately a 45% increase.

REHAB, REABLEMENT AND RECOVERY PERFORMANCE









- In terms of outcomes in January 2023 113 people finished reablement and an outcome was recorded. The number of people who went into long-term care in either community care (home care) or a placement were 36 = 32%, meaning where outcomes were recorded 68% did not progress into adult social care long-term packages. Of the 36 who went into long-term care, 33 went into home care packages and 3 into a placement. Of the 33 who went into home care 12 did so at a reduced package of care from when they were initially discharged into reablement (represents 36%). This means reablement interventions help the local authority avoid on going care cost. In February the trend is continuing with 73% having not LBWF funded services post reablement. In March 23 84% did not progress into long-term adult social care. In April 23 77% did not progress into long-term adult social care
- The average LOS in 2022/23 is on average 1 days less in 2022/23 than in 2021/22. The average LOS is 33 days. Generally people can receive up to 42 days support, but for some people they choose to end services early as they no longer need the care and support.
- An indicator around readmissions based on recorded data in the discharge tracker is being developed and will be presented in this report as soon as is available.

North East London Health & Care Partnership

NHS North East London

Managing quality and performance within Waltham Forest

An update on implementing a place system approach to quality

Monday 03 July 2023 Waltham Forest Health and Care Partnership Board

Executive Summary / Summary of Key Issues:	Purpose of Paper / Ask of the Board:

• The Waltham Forest Health and Care Partnership Board has an ambition to promote and improve quality across the system
• This paper summarised the progress to date in establishing the Waltham Forest Quality Sub Group of the Partnership Board and sets out the evolving approach to quality across the system and the data/ information sources used to inform the Quality Group
• The paper also summarises the partnership risk register
• The paper identifies the key escalations from the Quality Group to the Board
	• To note the progress establishing a partnership approach to system quality in WF
	• To note the review of the risk register in relation to the Board's programmes of work
	• To note the areas of escalation from recent focussed reviews and issues raised by the group as follows:
	• Single biggest issue affecting quality raised by BARTS in the June review was the delays for residents with MH presentations in A and E.
	• System action plan being developed. Need to agree locally where the oversight for this plan sits
	• The group holds an overview of all inspections across health and care and has had a particular focus on improvement planning in relation to 3 x primary care practices which have CQC improvement plans in place.
	• Risk register:
	  • CYP risks escalated regarding SEND inspection, known system risks and gaps
	  • LD – Moore ward temporary closure risk of out of area placements discussed and highlighted and plan noted
	  • Risk log for prevention and wellbeing programme will be developed as refreshed programme mobilises

Engagement:	**Specific Risks:**
• All partners are represented on the Quality Sub Group	• The risk register for the partnership is attached

Progress since last update

Waltham Forest Quality and Performance group has been established as a sub-group of The Partnership Board

Dr Ken Aswani, Clinical Director chairs

TOR and membership have been agreed and the group has met in January, February, April, June

We have refined and adapted our approach to quality during this time.

Available Intelligence

Community Insights Reports

Through Healthwatch and the ICB Community Insight System identify trends, variations and differences in health and care – helping to tackle and reduce inequalities.

WF CQC Issues Register (TBD)

CQC ratings are available for a range of providers within WF – In order to fully utilise this information of CQC issues register will be developed by the ICB quality lead.

Further work is need to develop a process to act upon this intelligence.

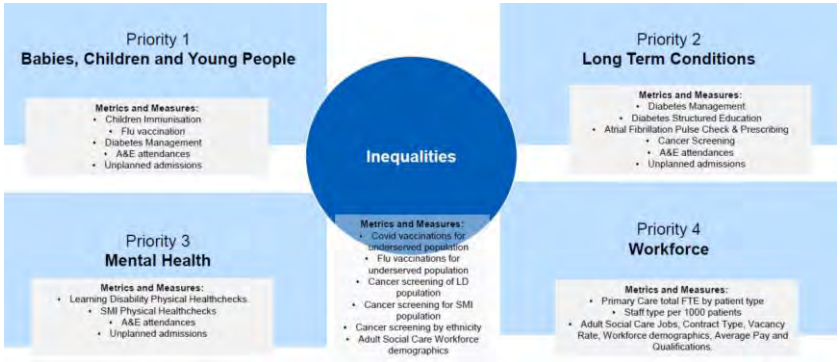
What ratings should lead to action?

Key Question:
What intelligence sources are missing?

ICB Priorities

Data is available at a Place level through the ICB Quality and Performance Framework.

The Framework is centred to four NEL ICB priorities around BCYP, LTCs, Mental Health and Workforce



Do these priorities meet WF quality priorities?

WF Place Risk Register

Through the review of our PbP risk register we will be able to review the highest areas of concerns across the partnership and address any quality concerns within our transformation work.

In addition to reviewing the escalation of quality issues through risks we will need to ensure system quality issues are feed down within our transformation programmes at Place.

LIKELIHOOD	Impact				
	Very Low (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Very Low (1)	1	2	3	4	5
Low (2)	2	4	6	8	10
Medium (3)	3	6	9	12	15
High (4)	4	8	12	16	20

How do we best use risks to address and highlight quality issues?

WF Quality and Performance Group: Our Approach

- Review of Quality and Performance Dashboards (quarterly)
- Deep dive from 1 partner/theme of their approach to quality and and their escalations and risks
- Health Watch Insight Reports specific to the provider/ theme presented
- Patient Experience insight to support focus (where available)
- Escalations/ Exceptions from workstreams/ partners
- Risk Register Review and update for all programmes in the partnership

Escalate to Partnership Board NEL ICS Quality committee as necessary by exception

Forward agenda

- June – Barts Health focus
- August – NELFT focus
- October - Adult social care focus
- December – Primary Care

Risk Register Update

Risk	Likelihood (1-4)	Impact (1-4)	Risk Rating
There is a risk that we will not deliver the business case for community health service transformation and not deliver the reductions in acute admissions required to support a new WX hospital	2	3	High
If demand for primary, health and care services continues to exceed capacity within system then primary care will be unable to contribute to partnership priorities regarding LTC management, wellbeing, and proactive care leading to an increase in health inequality and unplanned attendances to WX front door.	3	3	High
If we are unable to keep people well in the community and respond to escalating urgent care response needs in a timely way then the extreme pressure on hospital beds will continue .Increased pressure on this risk related to workforce availability linked to ongoing industrial action.	4	3	High
If we are unable to coordinate and target our resources to prevent, manage and treat LTCs then WF residents will continue to have experience poor outcomes.	3	4	High
If demand for equipment continues to increase due to earlier and more complex hospital discharges, then there will be significant pressure on health and social care equipment budgets.	3	2	High

Risk Register Update

A full copy of the risk register is attached to the agenda and here

Microsoft Excel Worksheet

The summary of the overarching risks for the partnership:

Risk	Likelihood (1-4)	Impact (1-4)	Risk Rating
If we are unable to recruit and retain clinical and care staff across our system and respond to the impact of the cost-of-living crisis is having on our staff, then we will be unable to provide safe services and will be unable to transform services for the benefit of residents	3	3	High
If our residents continue to experience extreme hardship due to the cost-of-living crisis then they will find it difficult to engage with services and to adhere to keeping well advice.	3	2	High
If we fail to implement our new Integrated Care System quickly and efficiently and ICB ways of working then this will impact on operational delivery, transformation, and engagement.	3	2	High
If we have insufficient high quality community estate capacity in WF we will be unable to deliver the out of hospital transformation of services required.	3	2	High
There is a risk that if we fail to coherently describe and explain the WF partnership and IC transformation programme to residents and staff then we will fail to engage them and deliver key aspects of the programme and get the political, clinical, and community support required to deliver a programme at scale.	2	2	Medium

Escalations to Board

BARTS deep dive:

- Single biggest issue affecting quality raised by BARTS in the June review was the delays for residents with MH presentations in A and E.
- System action plan being developed. Need to agree locally where the oversight for this plan sits

Primary care

The group holds an overview of all inspections across health and care and has had a particular focus on improvement planning in relation to 3 x primary care practices which have CQC improvement plans in place.

Risk register

- CYP risks escalated regarding SEND inspection, known system risks and gaps
- LD – Moore ward temporary closure risk of out of area placements discussed and highlighted and plan noted
- Risk log for prevention and wellbeing programme will be developed as refreshed programme mobilises

North East London Health & Care Partnership

NHS North East London

2023/25 Better Care Fund Plan

Author – Simone Lozer, Integrated Commissioning Manager

Presented by – Anna Saunders, Assistant Director of Integrated Commissioning

Monday 3 July 2023 Waltham Forest Executive Group

Executive Summary / Summary of Key Issues:	Purpose of Paper / Ask of the Board:

• Responsibility and accountability for the BCF has been delegated to the Health and Care Partnership Board from the Health and Wellbeing Board.
• This year, the BCF plan is biennial and consist of:
  • BCF narrative plan which covers the financial years 2023-25
  • Expenditure plan - ask for projected activities to cover two years, with year two plan being provisional.
  • ASC Discharge Fund grant, included in the expenditure template –ask for projected activities for one year, areas are to agree the ICB allocation for the joint plan.
  • Capacity and Demand plan is included in the expenditure template, the plan is for one year, there will be an asked for it to be refresh ahead of years 2.
• The deadline for submitting the 2023/25 BCF plan was 28 June.
• Due to meeting dates Mays board delegated sign-off of the plan to the Executive Group.
	For the Board to have overview of the 2023/25 BCF plan and oversight of the submitted BCF plan.
	
	For the Board to note the various plans that makes up the 2023-25 BCF plan.

Engagement:	**Specific Risks:**
• All plans were produced following engagement with key stakeholders across the ICS and Provider Collaborative. • Plans were presented to key stakeholders at the BCF Operational and Oversight Group for input • The financial plan was agreed with the input from the finance sub-group. • The 2023/25 draft BCF plan was reviewed by the regional team at the end of May, this allowed us to adapt our plan following their feedback	• BCF Plan has been submitted but there is a risk that the BCF National Team may come back with clarification/s so the final plan may face changes • Fortnightly reporting for the ASC Discharge Fund has resumed, this is creating system pressure on resources. I

- London Borough of Waltham Forest
  - Commissioning representative
  - Public Health representative
  - Adult Social Care representative (DASS)
  - Housing representative
- Barts Health NHS Trust (Barts')
  - Whipps Cross Hospital representative

North East London Foundation Trust (NELFT)

- NHS North East London ICS
  - Commissioning representative
  - Director of Local Partnerships
  - Primary Care representative
- Healthwatch Waltham Forest
- VCS Leads

Partners have been engaged in the development of the Waltham Forest BCF plan and have been asked to sign off the plan through the Waltham Forest Health and Care Partnership Board. This has ensured that the BCF plans reflect the integrated priorities of the system and have a joint ownership. The Waltham Forest Place Based Partnership recognises the value of the VSCFE in defining and delivering outcomes for our local communities' wellbeing. Funding has been made available from the Place Based Partnership to enable a VSE Leadership Group to be established and resources for VCS leaders to contribute to transformation workstreams.

The VCS partners have been involved in shaping system priorities through the Digital Enabler programme, Home First, Care Closer to Home, Centre of Excellence and Marmot Reducing Health Inequalities workstreams, the Better Mental Health For All Steering Group and via the Partnership Board.

As an integrated Place Based partnership, Housing colleagues have been involved in the development and shaping of the plan via the multi-disciplinary approach to delivering the Disabled Facilities Grant (DFG), and the Housing, Adult Social Care and Health forum which has a regular focus on improving the local rough sleeping and homelessness offer.

Governance

In line with national policy, the Waltham Forest Health and Wellbeing Board (HWB) has ultimate governance responsibility for the Better Care Fund.

The HWB has delegated, governance, oversight and accountability for the Better Care Fund to the Waltham Forest Health and Care Partnership Board.

The Partnership Board is the formal oversight, challenge and escalation forum for the management and delivery of the Waltham Forest integrated care strategy. It has strategic oversight of the implementation of the care transformation work streams involving the ICB, LBWF, Barts, NELFT, representatives from primary care and the voluntary sector and the local community.

The purpose of the Partnership Board is as follows:

- To improve the health and wellbeing of the residents of Waltham Forest.
- To hold executive responsibility for borough planning and delivery of community development and integrated care provision.
- To hold executive responsibility for the delivery of agreed transformation programmes.
- To promote integration between community health services, primary care services and social care services.
- To involve, engage and co-produce with Waltham Forest residents.
- To deliver through population-level health management approaches, using data insight and intelligence to influence priorities.
- To align organisational priorities and agendas.
- To escalate and address local risks and issues.
- To ensure the local community is engaged in system transformation that leads to impactful outcomes for residents.

In addition, The Waltham Forest BCF Operational and Oversight Group provides operational oversight of the Better Care Fund programme and is responsible for ensuring that national, planning and reporting requirements are complied with, and reporting is completed and submitted as required. And that all stakeholders are involved in BCF planning. The BCF Operational and Oversight Group meets six weekly and as determined by the Chair. On behalf of the Waltham Forest Health and Care Partnership Board its remit is:

- Ensure local compliance with national BCF Policy Framework and Planning Requirement Guidance.
- Be responsible for the annual revision, development, and submission of the BCF Plan.
- Be responsible for ensuring the timely completion and submission of monitoring returns and end of year report.
- Ensure BCF programme of investment meets the requirements of the BCF guidance and supports wider integration within the Integrated Care System (ICS).
- Ensure that a current Section 75 Agreement for the relevant BCF financial year is place between the London Borough of Waltham Forest Council and NHS North East London Integrated Care Board (ICB) for the pooled Better Care Fund.
- Review the operation of the BCF and have oversight of performance issues relating to the Individual services.
- Review and agree annually revised Schedules as necessary, ensuring changes are communicated to the Waltham Forest Health and Care Partnership Board.
- Agree variations to the Section 75 Agreement for the relevant financial year and report details of variation to the Waltham Forest Health and Care Partnership Board.
- Agree a register of risk and review as necessary.
- Providing progress reports to the Waltham Forest Health and Care Partnership Board quarterly
- Be responsible for local compliance, planning and reporting requirements for funding additional to the Better Care Fund.

Waltham Forest Place
Base Governance Arra

Figure 1

Executive Summary

The Waltham Forest Better Care Fund will continue to support the delivery of our system's ambitious programme of transformation and integration of community services in Waltham Forest.

The Waltham Forest health and care system is in a strong place in our integration journey and our partnerships continue to mature and strengthen. Led by our multi-agency Integrated Health and Care Partnership Board, the last 4 years has seen the local system adopt and agree an Integrated Care Strategy for Waltham Forest which has enabled a truly ambitious business case to be developed and agreed that looks to transform and develop how pre-emptive anticipatory and intermediate care is delivered in Waltham Forest. This is in addition to the work delivered by the Better Care Fund as a core enabler to the further delivery of our ambition to be leaders in the delivery of integrated care.

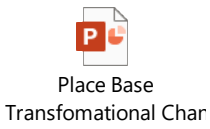
We have a clear vision which encapsulates what we want to achieve for our local population.

"Our aim is for the population of Waltham Forest to have healthier lives by enabling them to start well, live well, stay well and age well, supporting each individual through to the end of their lives. We will do this by working together, as partner organisations and with our residents, to improve health outcomes and reduce health inequalities."

The Health and Care Partnership Board and the Health and Wellbeing Board have committed to seven key measures of success:

- Addressing historical challenges and gaps in investment
- Transforming the way, we do things to deliver better outcomes for our residents
- Practically addressing significant health inequalities made worse by COVID
- Ensuring that our new hospital is viable and part of the wider community
- Developing a shared vision and narrative – making it real for residents and staff
- Agreeing how system partners will take decisions together in line with our ambitions
- Harnessing our combined resources to make it happen

Our Integration is underpinned by a number of transformational change programmes as shown in (Figure 2) in the embed slide.



Additionally, our Key Priorities as a Place Base Partnership is to enable the population of Waltham Forest to have healthier lives are core priorities as shown in (Figure 3) in the embed slide.

The BCF has been fully reviewed and refined to ensure all schemes are adding value to our system objectives to transform community service provision in line with BCF National conditions.

Planning for the use of the Adult Social Care Grant has taken place and alongside this prioritization, and the system has agreed its key priorities for investment and sustainability for 23/25 are:

Home First

The Integrated Hospital Discharge Hub **(Schemes 18and 19)** remains pivotal to the work of supporting the local Acute setting, Whipps Cross Hospital, and out of borough hospitals with processes being strengthened and streamlined over the next year to continue to support the system in returning our residents to their own homes as quickly and safely as possible, wherever this is feasible and practical.

The 23/25 plan retains a focus on Intermediate care services such as our NELFT-run Rapid Response Community Health service **(Scheme 14)** and Local Authority commissioned Reablement services **(Scheme 13)** within the BCF funding, both for admission avoidance as well as hospital discharge support and will continue working closely with our rehabilitation and therapy services **(Scheme 5,16)** as the Integrated Care transformation begins to take shape.

The Discharge Hub is now an established model of practice, in 2022/2023 the Hub discharged 75% of people home to their usual places of residence within 24 hours. This is above the 60% target set by the then CCG commissioners.

The 23/25 plan retains a focus on Intermediate care services such as our NELFT-run Rapid Response Community Health service **(Scheme 14)** and Local Authority commissioned Reablement services **(Scheme 13)** within the BCF funding. Both supports admission avoidance as well as hospital discharge and will continue working closely with our rehabilitation and therapy services **(Scheme 5,16)** as the Integrated Care transformation begins to take shape.

The reablement care provider capacity was initially increased during the pandemic to over 1600 hours per week, which has continued to be provided in 22/23. The Adult Social care grant is also being used to supplement our Bridging service. This ensures that residents being discharged from hospital for whom a care package cannot be secured same day are able to have a package of care provided by our community service provider's integrated team.

The 23/25 plan continues to use IBCF funding to invest in step-down beds **(Schemes 24, 38),** to support hospital discharge and support individuals to return to the community, also ensuring that every opportunity is taken to keep our residents out of residential and nursing placements and in their own home, as independent as possible.

Care Closer to Home

The Proactive Anticipatory Care Closer to Home model is being developed and enhanced to identify individuals who are deteriorating, or otherwise at risk of crisis and support them with a multi-disciplinary approach.

To support this the Waltham Forest 23/25 BCF plan continues to invest in Community Health Services **(Schemes 3, 5,16,17)** alongside Extra Care and Homecare provision **(Schemes 21,**

7, 40 and41) that will be brought into Multi-disciplinary Team working as the Care Closer to Home transformation programme is further developed.

Promoting Wellbeing

In Waltham Forest services addressing loneliness and social isolation **(Scheme 20 and 35)** falls within our Promoting Wellbeing programme; are being funded to ensure that individuals who may be at risk of future deterioration and negative impacts of loneliness are supported to remain at home, engaged with their communities rather than accessing Primary and Community Health provision.

National Condition 1: Overall BCF plan and approach to integration

As stated above, given the strong partnership arrangements, joint vision and agreed investment in future community transformation, further integration of services remains a key priority for the Waltham Forest system.

Substantial work has been undertaken in Waltham Forest to develop an integrated care strategy and joint approach to system transformation comprised of our key priorities.

- **Home First** – Supporting Admission Avoidance and Hospital Discharge, wherever possible focusing on enabling our residents to remain at home for as long as possible.
- **Care Closer** to Home – Proactive Anticipatory Care bringing multi-disciplinary teams together to identify individuals who may be at risk of deterioration and support them to remain in the community
- **Promoting Wellbeing** – Services and approaches that support residents to maintain their health, wellbeing and independence by intervening early and redirecting away from formal Health and Social Care.

These priorities and strategy are aligned to the Whipps Cross Hospital Redevelopment Programme and NHS North East London ICS and Place-based Partnerships. A consolidated business case for system transformation and new models of care for Home First and Care Closer to Home was approved in January 2022 resulting in significant additional investment in Waltham Forest Community Services in 2022-24 in line with our shared vision. 22-23 saw this transformation begin and has also led to a restart of our Promoting Wellbeing board to ensure this continues to be aligned to our system strategy. All of these programmes are overseen by partners from across the local system.

The formation of NEL Integrated Care System in July 2022 has created further impetus for place-based integration. The partnership is jointly lead and chaired across health and social care and leads and oversees service transformation and integration in Waltham Forest.

Integrated Commissioning in Waltham Forest (part funded by Scheme 43)

Further to the above, Waltham Forest has a fully integrated commissioning team in North-East London. Commissioning resources from LBWF and the NHS North-East London were formally integrated in March 2020 and are led by an Integrated Assistant Director of Commissioning. The iBCF contributes to the part funding of this team who have a lead role in the borough for supporting the development and implementation of our Integrated Care Strategy and commissioning individual initiatives funded by the Better Care Fund. As well as the Integrated Care Strategy programmes, there are a number of cohort specific integrated commissioning programmes e.g., Mental Health, Learning Disability which have been

led/developed/supported by the Integrated Commissioning team. Finally, the Integrated Commissioning team have led on work to deliver enabling services that are used across the system, such as the Integrated Community Equipment service **(Scheme 1 and 39)** which allows both NHS and LA staff to prescribe equipment under a single contract.

This demonstrates not only how we are enabling joint and integrated commissioning but also how BCF funding helps us to realise the benefits of stronger partnership working and joining up our planning, funding and commissioning of integrated services.

The formation of Place Based teams as part of NHS NEL ICS will enable further integration of roles and functions across health and care and developing these opportunities is a priority for the partnership in 2023/24.

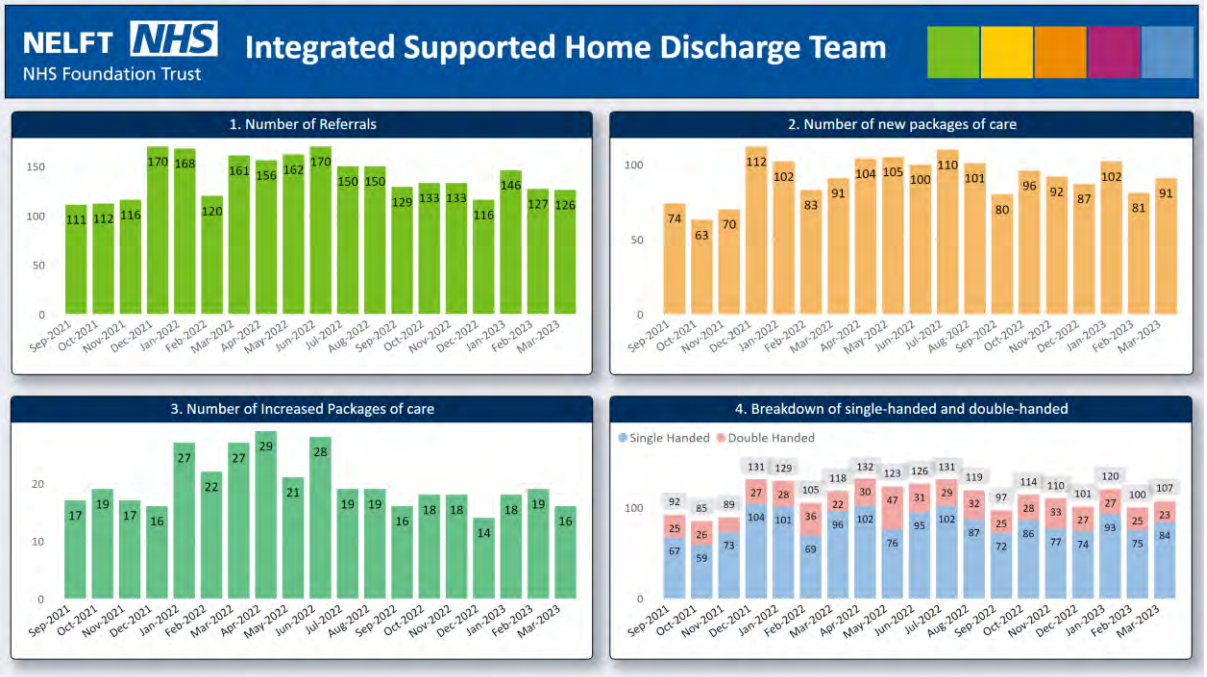
Home First (HF)

The Home First model of care developed as part of the Integrated Care Business Case ensures a system-wide approach to integrated intermediate care services. The ethos of Home First is always seeking to ensure that residents return or remain at home with the right support around them, to maintain/regain their ability to be as independent as possible.

The Whipps Cross Integrated Discharge Hub (IDH) is fully embedded in our system and following the lessons learned from the past two years is now looking at ways to enhance and improve discharge processes. The IDH now has a substantive staff team and is a key plank in the Home First model of our Integrated Care business case, with key ambitions over 23/24 to streamline and enhance in-reach to the Hospital and reduce length of stay in hospitals wherever possible.

The discharge to assess (D2A) model **(Scheme 4**) is now fully embedded within the system and this has been supported by bridging and reablement provision **(Schemes 5,13,14 and 16)**, which will be recommissioned during 23/24 to ensure that this is as streamlined a service as possible and is also available as an admission avoidance offer. Other Home First transformation schemes include: investment in the Rapid Response team to ensure a two-hour response to residents in urgent need in their own home and the addition of a Falls Pick Up scheme **(Scheme17)** within Rapid Response to avoid Emergency Department attendances and acute admission.

The reablement service **(Scheme 13)** continues to support pathway 1 discharges for people whose function has deteriorated since hospitalisation and need new or additional care support on initial discharge home. The service remit has expanded at the beginning of the pandemic from a defined set of criteria and 2 years on continues to provide reablement care and therapy for most pathway 1 patients requiring single or double handed care. Reablement care provider capacity was increased to meet demand due to covid. 2022/2023 reablement capacity was over 24,400.33 hours per week.



The service continues to see high numbers of patients discharged with double handed care. The team has had additional staff investment to include a band 7 clinical lead physiotherapist and a full-time administration staff. In addition, there is an apprentice physiotherapist working in the team, the additional staff have made a positive impact on the team being able to support patients in a timely manner post discharge. The service supports all those along the reablement spectrum from those motivated to maximise their independence to those with limited motivation therefore some patients may not reach desired outcomes however many of the patients reach their reablement goals and do not need long term care following an episode of reablement care/therapy.

The team has worked with system partners to gain patients feedback on their experience of the discharge process and reablement care/therapy post discharge. The feedback has been used to improve services, including contributing to the development of a patients leaflet for those discharge with carer support.

Our Bridging care scheme (**Scheme 6, 15, 18and 19)** continues to run a 7-day service working flexibility to provide emergency care packages on the day for Waltham Forest residents who would otherwise remain in hospital while awaiting a care package provider to be confirmed. The service continues to enable the system to implement the 'why not home, why not today?' principle by offering timely, flexible care.
The bridging care is an integral part of the Discharge Hub and has representation in the twice daily discharge hub calls where they jointly identify and offer care support to people who can be discharged with bridging care support on the day.

In 2022/2023 the bridging service achievements are:

- Discharges for patients needing carers trained in Stoma were often delayed as care agencies could not be identified. Bridging service carers were trained in Stoma care

and the service has supported patients who needed stoma care resulting in timely discharges for this group of patients.

- Additional winter funding (£130 000) was allocated to the Bridging service to increase capacity and support in order to reduce winter bed pressures in acute hospitals
- The service supported discharge for 936 patients which is a 60.3% increase on April 2021-March 2022.
- Bridging also supported a number of patients in the community, with referrals from Rapid Response and other community services, thereby preventing hospital admissions.

Bridging service priorities for 2023/2024 are:

- Continue to provide same day care support for patients to support discharges and admission avoidance where a care agency has not been confirmed on the day through brokerage team.
- Further Bridging staff training in physical health skills to enable the service to support patients with more complex needs in order to speed up discharges.
- Review Bridging service as part of the reablement recommissioning work under the Home First transformation work.

The following is an evaluation of the service:

Bridging Service Evaluation April 2023.

The priorities for 23/25 are to continue to implement the Integrated Intermediate Care business case and progress the development of the model of Intermediate Care in Waltham Forest, including rehabilitation **(Scheme 5, 15 and 16)**, therapeutic input, reablement and clinical oversight via virtual wards. This will include reviewing the recommissioning options for of the reablement therapy, personal care and bridging services within Waltham Forest, with a view to streamlining these services to create a more therapeutic-focused offer and increasing the number of people 65+ at home after 91 days. This will ensure the best possible discharge that enables keeps residents to remain safe and well at home through good intermediate care services provision.

We plan to maximise the number of P1 discharges for adults of working age and older people via the universal reablement offer – a key part of our Home First approach.

We anticipate the trend of lower mortality rates to continue and the outcome measure for over 65s at home after 91 days to improve closer to pre-pandemic levels (plan to achieve 91.5%), despite the challenges faced with increasing service demand as the service moved from a narrow pre-pandemic criteria to a universal offer in March 2020. To illustrate, the number of discharges of older people into reablement in 2022-23 was 50% higher than the year ending March 2020 (2019-20) and 2023-24 projection is 75% higher.

We will expand this service into an admission avoidance offer by strengthening the existing community reablement offer, through the development of the enhanced domiciliary care offer **(Schemes 12, 13, 21,22 and 25)** linked to primary care MDTs and by interfacing with the local 15 minute neighbourhood model.

Our Care Closer to Home model presents a significant opportunity to create a genuinely integrated system that provides person centred holistic 'care' that transcends organisational boundaries.

Care Closer to Home (CC2H)

The Care Closer to Home Programme incorporates the Centre of Excellence and Proactive Anticipatory Care. These are supported by services funded through the BCF to ensure that residents of Waltham Forest are identified proactively for health or care interventions and that the right team of professionals are brought together to ensure that care delivered can keep individuals well at home and independently for as long as possible.

Centre of Excellence (CoE)

The top 10% of people who get admitted to the local hospital accounted for 46% of total non-elective spend in 2019. These People typically have 30+ admissions to hospital of which a significant amount are avoidable, with a third of admissions being very short length of stays.
A key aspect of the model is to anticipate and manage escalating complexity in a person proactively before it is too late. Clinicians felt that we needed a one stop shop environment where professionals can interact, plan and mobilise enabling care without delay.

The Centre of Excellence will comprise:

Complexity (and frailty) hub - Supporting people with frailty and escalating complexity to stay well and out of hospital through an integrated, single stop, enabling multi-faceted response

Long Term Conditions (LTC) hub - Brings multi-specialisms and multi-agencies together to provide holistic assessment and enabling support to people with complex LTC needs

Wellbeing Lounge - Providing tailored solutions to each individual's needs in the context of their everyday life and connecting them to the wellbeing network

Digital Hub - Virtual remote monitoring, escalation and response unit allowing timely management of escalating needs. Wil also provide telemedicine functionality and use of assistive tech to support residents (cohort/s to be identified)

Learning, innovation and training hub - Developing local current and future leaders and providing opportunities for cross-professional learning and development. The hub will also provide training and support for carers and the voluntary sector.

Digitally enabled decision-making processes will reduce unwarranted variation, ensuring people get the right care, at right time, in the right place, from the right professional(s) at the right cost.

As the models of care have emerged during the course of year one (2022/23), the preferred direction of travel is a hybrid model with some service elements co-located at Whipps Cross, some elements within the community and others to be delivered through a digital model.
It is the ambition for Care Closer To Home models and pathways to work through locality hubs. These hubs are in concept stage with ambitions to accelerate development through the use of existing sites.

In year one (April 22-March 23), remote monitoring of care homes through Digital Hub support was launched (service went live 30 August 2022). Two older adult residential care homes were fully onboarded to access the Digital Hub service, with a plan to onboard the remaining 13 homes by the end of March 2023. At the end of March, the task & finish group collated lessons learned from the year one and used this to shape the wider Digital Hub model with a view to launching this during year two.

The second element of work which started in year one was the planning and design of the LTC and Complexity Hubs. The hubs will initially focus on four key specialty areas: Diabetes, Cardiology, Respiratory and Renal. There are plans in 2023/24 to be able to provide a face-to-face service, starting in September 2023.

The remaining two elements of the Centre of Excellence – Wellbeing Lounge and Leadership, Innovation and Training Hub – are lined up to enter planning phase later this year in 2023/24.

Proactive Care:
The Care Closer to Home has five components connecting the model of care:

Multi-disciplinary team working at a network level
The intention is to deliver a more proactive, anticipatory, and coordinated responses to prevent deterioration or escalation occurring for frail and/or complex patients who are selected using a single, shared 'identification' tool and process. The multi-disciplinary approach comprises of three key elements:

- Proactive identification
- Collaborative decision making
- Coordinated delivery

The Multi-disciplinary teams (comprising of therapists, community matrons, nurses, GPs), that are being developed at a PCN level by Care Closer to home will work not just our community health and primary care colleagues, but also alongside Extra Care and Homecare provision **(Schemes 3, 7, 21)** to allow conversations that address the whole person, making every contact count and potentially reducing the likelihood of individuals having to re-tell their story to multiple professionals.

GP multidisciplinary meetings have been progressing and the evaluation outcome will enhance PCN Meetings planned for Summer 2023.

Care Homes Multi-Disciplinary Support
Care home MDTs will enable early interventions, to prevent deterioration, minimise conveyance to acute settings and where patients are admitted, improve the quality of the discharge back to care home.

15 Care / Nursing Home were identified to participate in the programme. The roll out of multidisciplinary meetings in care homes started in September 2022, and 14 out of the 15 were holding monthly meetings by March 2023.

Complex LTC Management
Multi-disciplinary teams will work together in the management of complex LTC's. There will be a focus on the 3 most prevalent diseases in Waltham Forest with patient pathways co-designed. Specialist teams including diabetes, heart and respiratory teams will be aligned to each Primary Care Network (PCN) and be available for advice and guidance.

Where it is felt a structured training intervention will be beneficial, specialist support and training interventions will be available.

Primary Care Mental Health Liaison
Multi-disciplinary working and care coordination will reduce secondary care mental health referrals for people with emerging MH problems that are often triggered or exacerbated by other simultaneous issues e.g. social/housing/relationships. The programme will work with community MH services to enhance existing roles within primary care through regular MDT working at a neighbourhood level.

Enhanced Domiciliary care support
The Enhanced Domiciliary Care support will link our BCF funded Community Health Services (Schemes 12, 13, 21 and 22) to enhance the skills of our care workers as they have greater access to clinical support and will also allow our residents to benefit from a more holistic approach to care and support.

This element will support shared care planning, increase skills of care workers to spot potential concerns e.g. medicines. The programme will equip care workers to be more skilled in identifying risks, taking a more proactive approach. There will be better engagement and support to carers to build skills and resilience, recognising these individuals play a critical role in supporting day to day activities of looking after loved ones and family members. Collaborative working with the Integrated Commissioning teams will ensure a plan for roll out is in place for Autumn 2023.

National Condition 2 - objective 1:

<u>Enabling people to stay well, safe and independent at home for longer</u>

As mentioned above the Care Closer to Home Programme incorporates both the Centre of Excellence and Proactive Anticipatory Care. These are surrounded and supported by services

funded through the BCF to ensure that residents of Waltham Forest need health or care interventions are identified proactively and that the right team of professionals is brought together to ensure that care is delivered that can keep individuals well and at home independently for as long as possible.

The workstreams within the Care Closer to Home Programme such as the Enhanced Domiciliary Care support will link our BCF funded Community Health Services **(Schemes 6,7, 42, 43 and 44)** to enhance the skills of our care workers as they have greater access to clinical support and will also allow our residents to benefit from a more holistic approach to care and support.

The Multi-disciplinary teams (comprising of therapists, community matrons, nurses, GPs) ,that are being developed at a PCN level by Care Closer to home will work not just our community health and primary care colleagues, but also alongside Extra Care and Homecare provision **(Schemes 7, 10,11, 21)** to allow conversations that address the whole person, making every contact count and potentially reducing the likelihood of individuals having to re-tell their story to multiple professionals.

The Frailty and Complexity hubs within the Centre of Excellence give access to consultants from Whipps Cross acute hospital, with the aim of allowing our most complex patients to continue to be seen in the community and reduce hospital admissions and improving access to strong clinical oversight in the community.

In addition to the above, the Disabled Facilities Grant is being used enable people to stay well, safe and independent at home for longer.

The Housing Adaptation Service supports all individuals regardless of their status under the Protected Characteristics under the Equality Act 2010. The service currently supports children, young people, working age adults and older people with a range of disabilities (physical, learning disability, neurodiversity, mental health) and from a wide range of cultural and ethnic backgrounds within the borough.

The Service supports vulnerable residents with disabilities to remain living at home and retain their independence and abilities. The service also enables informal carers to best support their relatives at home, reducing carer stress and the likelihood of carer breakdown.
In addition to meeting the residents physical health needs it also promotes the mental health and wellbeing of these individuals, their informal carers and their family members.

The Home Adaptations Team completed adaptations for 159 residents in 2022-23. The team is currently working with 184 residents in relation to the various stages of the adaptations process. This includes technical assessment, scheme design, technical surveying input, grant applications and work on site.

On 24/05/23 the Home Adaptation Team's waiting list for occupational therapy (OT) assessment was 535 residents. The number of people waiting includes an inherited backlog from the external Home Improvement Agency provider, plus new referrals since the service was insourced. Referrals are triaged and prioritised on receipt and the priority is reviewed if new information about the person's situation is received. Work is underway to audit all the

referrals for residents' waiting for assessment to ensure that the current priorities reflect the resident's stated needs and to reduce duplicate requests.

The most common type of adaptations includes level access showers, stairlifts and ramps to enable people to wash and bath safely, access their property, and live independently and safely at home. In some cases, larger adaptations such as extensions to the home to create extra space and rooms suitable for assessed needs may be undertaken with the permission of the landlord if it is practical and reasonable to do so.

National Condition 3 - objective 2:

Provide the right care in the right place at the right time.

Home First

As previously mentioned, the Home First model of care has been developed and ensure that a system-wide approach to integrated intermediate care services is in place. The Waltham Forest Home First Programme is comprised of admission avoidance and hospital discharge elements, with the aim of providing a comprehensive system-wide integrated intermediate care offer supported and led by BCF funded services.

We have robust community provision; we assumed the capacity of community services to be 10% more than demand. We also, have adequate process and arrangements in place to go out to the market to spot purchase if needed.

During 2023/24 and 2024/25 we will be moving towards full implementation of our Home First model, to deliver an integrated intermediate care service in Waltham Forest by 2024/25 that will help residents:

- Avoid unnecessary admission into hospital or residential care
- Be discharged back home from hospital as early as possible
- Be as independent as possible after a stay in hospital.

The services currently provided by both the NHS and Local Authority in intermediate care will increasingly move from working in silos to a single integrated intermediate care system.

During 2021/22 and 2022/23 we made good progress against our plan, which are summarised below:

D2A/IDH Improvements (Schemes 18,19 and 43) – Implementation and embedding of High Impact Change Model actions. Undertaken a review of our D2A Support Offer via a Local Government Association and Newton Europe project, resulting in a 10-point plan to address recommendations and findings. We agreed a Waltham Forest Discharge Plan for 2022/23 and reviewed our approach to patient and carer engagement. D2A resources and packages of care funding was agreed for 2022/23 and schemes were agreed by the partnership for use of additional funding of circa £2m available from the Adult Social Care Discharge Fund between

December 2022 - March 2023. Same day and next day discharges remain high and average 75%.

Admission Avoidance (Rapid Response Expansion, Scheme 14) - During 2022/23 we mapped services and gathered data from existing Admission Avoidance services and funded new additional roles to expand our Urgent Care Response within Rapid Response and Social Care. In addition, we have expanded the Urgent Falls Response service to operate 24/7 and 365 days a year, which is now part of a revised Appropriate Care Pathway between LAS and Rapid Response. Work was undertaken to strengthen joint working between the Emergency Duty Team, the Front Door and Rapid Response. Waltham Forest took part in a pilot about increased use of the urgent response car with London Ambulance Service and other local authority urgent care response teams (Barking, Havering and Redbridge). The pilot has shown some promising results for the residents of each Borough, including Waltham Forest. The pilot has been extended into 2023/24. Initial conversations have taken place with the Local Authority about the proposed new model for an integrated assessment function to support admission avoidance. Currently 96% of urgent care referrals are responded to within 2 hours.

Rehabilitation, Reablement and Recovery (Schemes 5,13, 15 and 16) – We have worked with key partners to clarify and agree the role Rehabilitation, Reablement and Recovery will play in a therapy-led Intermediate Care Service. An options appraisal for a new personal care service model to support intermediate care, including access to care services outside of core hours has been completed and endorsed by the Home First Executive. Service mapping of rehabilitation, reablement and recovery services is completed and initial conversations are taking place with secondary care therapy around our optimum therapy model and joint rotations between acute therapists and community therapists. Currently, 60% to 65% of people who are using reablement services for up to 6 weeks end services and do not go on to long-term adult social.

Virtual Ward – The pathway in and out of the current GP-led virtual ward model were agreed and initial capacity increased from the 40 beds to provide additional beds to support with more effectively managing winter pressures and increase early supported discharge. During 2022/23 the model of care for the new frailty virtual ward for Waltham Forest was approved by the Frailty Virtual Ward Clinical Reference Group with representatives from Tower Hamlets, Newham and Waltham Forest. Barts Health Trust was chosen as the new virtual ward provider.

Our priorities in 2023/24 and 2024/25 for Home First are focussed on scaling up services and implementing a fully integrated Intermediate Care Service that provides appropriate care and support services. They include:

Moving towards an Integrated Transfer of Care Hub that optimises the current teams engaged in pre-discharge and discharge. Bringing together in an integrated model, post discharge support services across community health and adult social care, and bringing VCSE services into the discharge and post discharge support process. Actions will also focus on the Whipps Cross Urgent and Emergency Care Plan 2023/24 ‘Route 76’, further implementation of actions to address the D2A Support Offer findings and work to better engage with patients and carers, including implementation of Bart’s ‘Discharge Ticket Home’.

Developing an Integrated Admission Avoidance Service underpinned by an integrated assessment function that can complete trusted assessments on behalf of partners. We will ensure there continues to be a robust crisis and urgent response offer that optimises joint working with partners. A key area of focus will be agreeing the new model's core function, processes and operating procedures, as well as, our MDT approach, workforce development and engagement with residents and wider agencies. Additional recruitment to new roles will continue to help us build increased capacity within the workforce.

Building an Intermediate Therapy Service that brings together therapy disciplines and current services to develop a Waltham Forest Intermediate Therapy offer. This will include bringing together Community Health and Local Authority therapy teams and closer alignment with acute therapies to work more fluidly across intermediate care, while recognising specialisms and working jointly with colleagues in secondary care. The service will play a lead role in rehabilitation and reablement and will care manage and provide therapy input for residents who are being supported by the new personal care service. Part of the work will also include integrated community equipment services, assistive technology and using the Disabled Facilities Grant, Housing Revenue Account funding and Home Adaptation Team to ensure people can be discharged promptly, safely and that homes are adapted where required to support on-going needs. We will recruit and appoint a Principal Therapist to drive forward cultural change.

Implementation of a new personal social care service that will replace the current Bridging and Reablement service to support all of intermediate care. It is anticipated that the new service will deliver up to 2,500 of care and support and have an extended reach over the current service, in so far as it will be able to support more complex conditions and provide more intensive support, including 24-hour care and support at home. The intention is to align the new service and capacity with the current community health provider, so as a system we can align this with our therapy service to maximise patient and resident outcomes.

Wider transformation work to further develop specialist pathways and provision such as the work to strengthen the integrated stroke pathway and deliver an integrated stroke and community neuro-rehabilitation offer for Waltham Forest residents.

Many of the previous BCF funded schemes already are within intermediate care. As the Home First transformation programme develops it may be necessary to change, develop and build on the schemes throughout 2023/24 and 2024/25 to better reflect the emerging partnership priorities and realign BCF, iBCF, DFG and Discharge Funding to integrate and fund the new intermediate care model.

Hospital Discharge

Our Integrated Discharge Hub is the single point for all transfers of care from hospital to home or other interim or permanent destinations.

It covers all discharges for Waltham Forest residents whether from Whipps Cross or out of borough hospitals. The Hub is a multi-agency response to the discharge guidance. It includes therapy and nursing staff from community health services, local authority social workers, brokerage officers, acute trust staff, administrators and a dedicated manager. Community health providers NELFT is the lead organisation, and the Hub provides a 7 day extended hours service.

Age UK Waltham Forest have been commissioned by Barts Health to provide a “take home and settle” service, particularly for pathway 0 and 1 patients. This includes making sure equipment can be delivered before discharge, there is food and heating on the person’s return home and a warm welcome.

The system follows the national requirement and a “discharge to assess” model is embedded in the system, with good practice being highlighted at a National level by DHSC. For Pathway 1 discharges we aim for same day discharge using either home care providers or NELFT’s in-house bridging service before this move into reablement provision commissioned by the Council (Schemes 15 and 16). However with the agreement of the Integrated Care business case and new Home First Model, work will begin in 22/23 to recommission the bridging and reablement services to create a joined up intermediate Care System that supports Waltham Forest Residents to return and stay at home.

Integrated Discharge Hub (IDH):

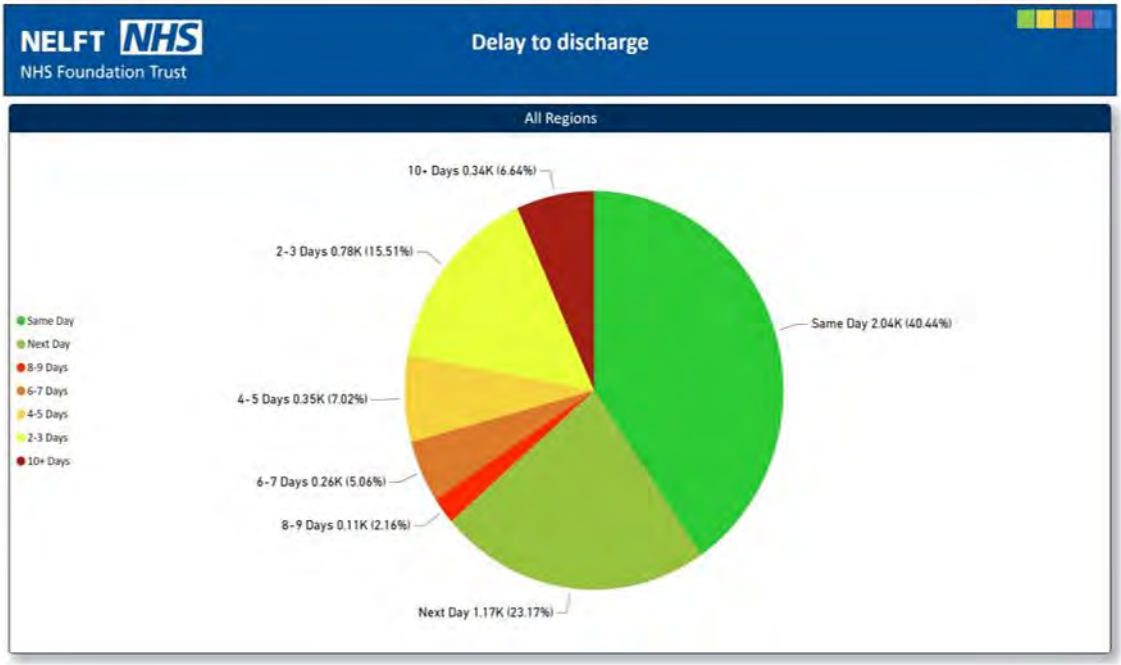
The IDH performs very effectively and has discharged 4992 people with complex health and social care packages during 2022/2023 (April 2022 to March 2023)

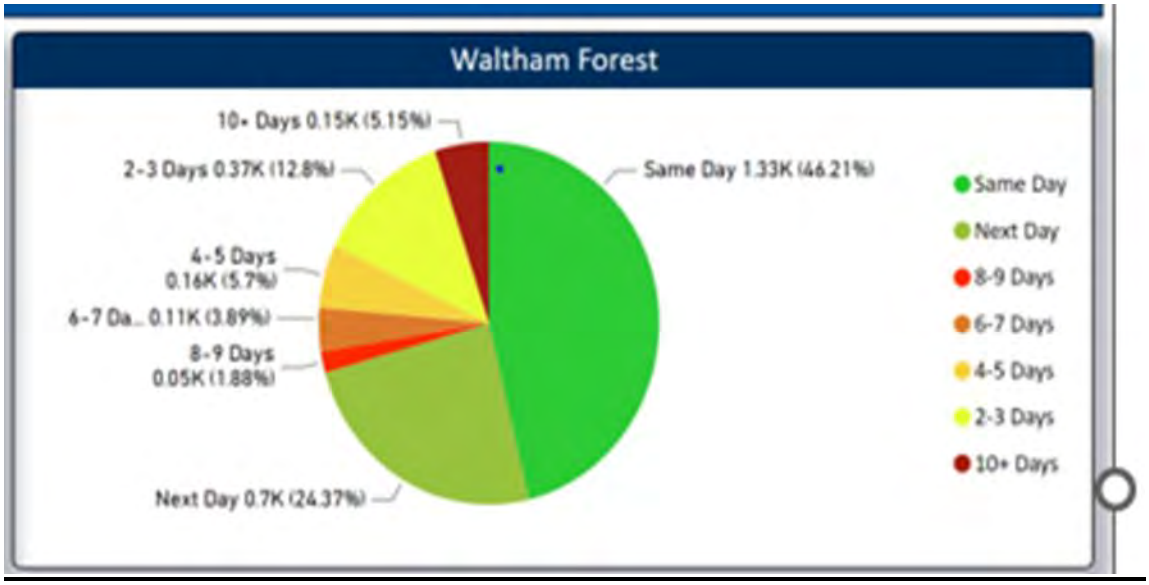
In 2022/2023 the Hub has discharged:

Pathway 1 – 3765 patients discharged to their usual place of residence with support from carers achieving 75% of people discharged to their usual places of residence with support from carers)

Pathway 2 - 737

Pathway 3 – 490





The Discharge Hub is continuing to discharge high numbers of people within 24 hours thereby demonstrating the positive impact on reducing length of stay in acute beds. The hub is achieving 40.44% of discharges on the same day and 23.17% of discharges on the next day. System partners working across the discharge hub are consistently looking at ways to improve patient experience and flow to increase the number of patients safely discharged from hospital.

The amount of activity going through the discharge hub remains high with 6497 patients going through the IDH in 2022/2023, January 2023 had 637 patients going through IDH which was the highest monthly figure for the year, in comparison with the 2022/2023 monthly average of 541.

IDH had additional £60 000 discharge funding which was used to increase Trusted assessor and clinical assessors capacity within IDH from January to March 2023, this saw increased numbers of discharges, in March 2023 IDH achieved 507 patients discharges which was an increase in discharges numbers compared to the 2022/2023 monthly average of 416 patient discharges.

IDH have worked with System partners across health and social care in gaining patients' feedback in order to identify areas needing improving in the discharge process.

Virtual Ward

Ensuring appropriate access to out of hours medical input and advice to help avoid admission/readmission and support more people to remain at home. This will build on existing services and planned development within services.

Transition from the current virtual ward service to the new frailty virtual ward, building bed capacity to achieve 69 beds in 2024 onwards. In addition, work will continue to develop and mobilise a Respiratory Virtual Ward.

IDH Priorities

- IDH priorities for 2023/2024 are to continue facilitating safe and timely discharges, by reviewing reasons for delayed discharges and implementing changes either at a system level and local level to improve discharge processes.
- Continue to work with patients, carers and voluntary sector colleagues to gain feedback in ways to improve patient/carer experience of discharge pathways.

As sated above the continued ambition for our 2023/24 and 2024/25 we will be moving towards full implementation of our Home First model, to deliver an integrated intermediate care service in Waltham Forest by 2024/25 that will help residents:

- Avoid unnecessary admission into hospital or residential care
- Be discharged back home from hospital as early as possible
- Be as independent as possible after a stay in hospital.

The attached stock take of the Home First programme for 2022-23. This sets out the achievements in 2022-23, the learning during the year and summaries the actions to be taken forward in 2023-24 within the Home First programme. The detailed work programme is also included below.

Home First Programme Plan v1 -

Home First Programme 2022-23

National Condition 3 (cont) - Discharge to the usual place of residence

As set out in previous sections, the local system principle of Home First is embedded in our discharge practice for pathways 1-3. The only permanent placements on discharge from hospital are fast track. In all other cases residential and nursing placements are interim. We plan to continue to build on the active delivery of this principle during 2023-25, strengthening practice and local MDT relationships, plus delivering further improvements in the local intermediate care offer such as re-commissioning the personal care element of Reablement, implementing the new virtual ward model and consolidating the local admission avoidance offer.

The focus for admission avoidance in 2023/24 will be on implementing the business case outcomes around 'Implementation of an Integrated Assessment Function for Admission Avoidance' and 'Fully embed pathways for community services to access medical support/expertise out of hours'.

Areas for further work led by the Rehab, Reablement and Recovery work group include training, education and practice around double handed packages of care and the re-commissioning of reablement-related personal care.
In 2023/24 there will be a focus on the transition from the current virtual ward to the new virtual ward, development of a detailed plan for scaling up the Frailty virtual ward as well as the emerging plans to commission and roll out a Respiratory Virtual Ward.

The High Impact Change model (HICM) is a key element of the D"A work group of the Home First programme and Divisional Director at Whipps is the Senior Delivery Owner.

National Condition 3 (cont) – Progress in High Impact Change Model

The Home First action plan for 2022-23 included the review of progress against each aspiration. We continued to strengthen the core Homelessness offer provided via Housing Services to develop a system-wide Homelessness & rough sleepers pathway. A dedicated Housing Officer to support discharge has been in place since January 2021**(Scheme 39)**.
IBCF funding continues to fund step-down beds in residential, sheltered housing and Extra Care provision to support transfers into the community within the Home First ethos where direct transfers home are not possible.

Some deliverables have rolled into 2023/24 including actions around ensuring the consistent application of criteria to reside, consistent implementation of the protocol agreed around Discharge Planning Tracking List (DPTL), a review of the system escalation protocol and work around patient engagement and carers, especially around implementing Bart's initiatives around Discharge Ticket Home, Whiteboard and Carers Passport. The feasibility and implications of creating a single discharge team combining Barts Health Complex Discharge Team and the Integrated Discharge Hub is being scoped.

High Impact Change Model.docx

National Condition 3 (cont) – Describe how you have used BCF funding, including iBCF and ASC Discharge Fund to ensure delivery of Care Act duties.

As set out in previous sections, the Local Authority's Care Act duties are generally undertaken after discharge following the D2A approach. The Hospital Active Recovery Team social care staff **(Scheme 6)** assess the needs of the person and their carers in the person's home or interim care bed, determining with them their ongoing care and support needs. This includes Care Act assessments following a period of reablement (pathway 1) and those placed in rehab or interim beds on pathway 2 & 3. The 2 social workers integrated in the CHC team **(Scheme 25)** undertake Care Act assessments as necessary when residents are determined not to be CHC eligible.

The local system will continue to ensure residents can return home to live independently using Home First principles including reablement, interim placements and home-based support with the aim of only a small percentage of people moving into in long term residential or nursing placements. Our 2023-24 projection of approx. 166 people is based on a 2-year trend in 65+ residential and nursing admissions (a trend we anticipate will continue) and a return to pre-pandemic levels (169 people in March 2019). There was a net increase of 12 residential placements and a reduction of 27 nursing placements during 2022-23. We have assumed a 6.5% increase. The trend is 10% but using Home First principles we aim to reduce the overall placement need.

Supporting unpaid carers (Scheme 26)

The Waltham Forest All-Age Carers Strategy has been refreshed and approved by Cabinet in April 2023 following its success in improving and enhancing the carers offer and processes towards supporting unpaid carers with a dedicated Strategy lead co-producing the strategy.

The refreshed strategy which has been now set for the next 3 years (2023 – 2026) incorporates revised commitments from lead stakeholders which have been themed under the following priority areas;

1. Easy access to information and support when Carers need it early into their Caring role
2. Carers to have increased opportunities to good quality support, including breaks, groups and positive opportunities
3. Carers rights and needs are better understood and recognised across Waltham Forest
4. Better care and support from services for the cared-for
5. Develop professional practice and process to improve identification and support across the system

The Waltham Forest Better Care Fund has a specific funding line for Carers (Scheme 26) within the NHS minimum contribution. This funds the Universal Carers support service commissioned by the Local Authority and provided by Carers First. This provides unpaid carers with information, advice and supports them to maintain their caring role whilst also maintaining their wellbeing.
Funding towards Carers First has also enabled us to undertake a Carer Contingency Pilot, working with NHS England to develop approaches to contingency planning in the event that Carers are unwell or affected by emergency situations.

This will be taken forward in 23/24 through our Carers Strategy refresh, developing an approach of embedding Carers Contingency plans in both practice and the system which will support the peace of mind and reduce mental strain for unpaid carers due to their caring role. Waltham Forest will also be taking forward work in 23/24 with North East London (NEL) to help influence and shape NHS Long Term Prioritise towards Unpaid Carers which includes;

1. Better identification and support for Carers
2. Supporting Carers with Emergency Planning (Contingency Planning)
3. Better support for Young Carers

As of April 2023, a Lead Carers Group has been formed by NEL with programmes leads from Health and the Local Authority which will initiate, develop and embed programmes that are designed to and meet deliver NHS Commitments to Unpaid Carers.

Identified Unpaid Carers:

- Young carers – as of 1st June 2023, there are 488 young carers and families that are known (identified) to the local authority.

- Adult unpaid carers – the local authority is currently reviewing its reporting systems and practices linked to adult unpaid carers, with the view to further enhance the quality of data that it holds.

Disabled Facilities Grant (DFG) and wider services

The delivery of Disabled Facilities Grants (DFG) sits within the Home Adaptation Service as part of Adult Social Care. This service is comprised of the Adult Social Care Occupational Therapy Team and the Home Adaptation Team which manages adaptations across all tenures In addition to overseeing adaptations, the Home Adaptation Service also manages the Integrated Community Equipment Service provision and budget and the Council's Telecare (Assistive Technology) provision.

Operationally there is a Major Adaptation Panel (MAP) which sits monthly and looks at proposed major adaptation schemes in terms of grant approval. The Panel is comprised of staff from Adult Social Care and Housing. In addition to grant approval and informing residents of their decisions, the MAP also deals with appeals and can offer advice and a forum to referring/assessing OTs and Technical staff. It works closely with colleagues in children's services to manage referrals, approvals and works.

The Home Adaptation Service manages the Discretionary DFG (DDFG) grant process, as part of the Council's Regulatory Reform (Housing Assistance) (England and Wales) Order 2022, housing assistance policy: Grants for Home Adaptations and Modifications in Waltham Forest, effective from 1st April 2019; and in line with the Disabled Facilities (DFG) Delivery Guidance for Local Authorities in England (published March 2022)

The following areas of support are offered:

- Major Adaptations – into owner occupied, rented and Council properties. Adaptations for owner occupiers, housing association or private tenants are funded via DFGs and adaptations for Council tenants are funded via the Housing Revenue Account
- Hospital Discharge Support – support for the system to manage discharges promptly and safely through flexible and targeted interventions and reduce hospital admissions and readmission
- Home Repairs and Renewals – to improve the home environment of disabled residents more quickly, taking a preventative approach
- Home Safety – support to make the home environment safe and reduce risk to residents, such as our work with HEET to provide affordable warmth for vulnerable residents
- Emergency Adaptations – assistance where work is required immediately, and it is not practicable to go through the mandatory process
- Re-housing, Relocation or Temporary Relocation Assistance Grant (Move On) – assistance to move on where undertaking a major adaptation is not feasible

The Home Adaptation Service based within LBWF Waltham Forest has been established since April 2022 when the Home Improvement Agency (HIA) service was brought back in house when the contract with the previous provider expired.

Since April 2022 the focus has been on embedding the staff team and developing new Operational policies and procedures.

From June 2023 all staff within the Home Adaptation Service will move onto LBWF employment contracts, terms and conditions.

Provide the right care in the right place at the right time

This Service enables the Health and Social Care system to remain sustainable by ensuring homes are adapted to meet the functional and mobility needs of disabled residents and their carers to enable them to remain living in their own homes, thereby reducing the likelihood that they enter the acute system or long-term care, which includes costly Residential and Nursing Home placements.

The service will continue to build on the partnership work undertaken with partners including Voluntary sector agencies such as Waltham Forest HEET. This is in relation to improving the health and wellbeing of vulnerable owner occupier residents by providing them with funding to support the renewal of outdated central heating systems and home insulation for residents with limited financial means, which is of particular significance and importance due to the current cost of living crisis.

During 2023/24 we will:

- Develop a Home Response Team that will manage, and coordinate agreed discretionary spend priorities, such as: safe, effective, and timely hospital discharge, admission and readmission avoidance and greater use of assistive technology. This team will allow us to potentially benefit from the Government's intention to fund a new service to make minor repairs and changes in peoples' homes, to help people remain independent and safe.
- Continue to Improve and streamline processes to ensure the team is able to offer information and advice around housing options and is able to deliver the required level of capital works and major adaptations schemes in line with funding and current demand.
- Review with partners emerging and changing priorities to identify new opportunities for use of DFG funding (to improve housing options) and other funding associated with Health and Social Care priorities.
- Continue work with Housing colleagues to support the timelier procurement of works (Dynamic Procurement System and/or frameworks) to move through the stages outlined in the new DFG Delivery Guidance.
- We will continue to focus on local operating procedures to simplify and maximise in year spend against our annual DFG allocation, to reduce carry forward of unspent grant (to meet agreed priorities)
- We will continue to develop an agreed performance and reporting framework to evidence the work of the service and how the DFG is supporting people to stay safe, well and independent at home for longer, ensuring we provide the right care, in the right place at the right time.

Throughout 2022/23 we have worked closely with wider partners in Health, Housing and the VCES sector and this work will continue throughout 2023/4 to jointly develop understanding of a new service model that allows us to better deliver on our integrated care ambitions, corporate priorities, and the opportunities to improve resident outcomes via the health and adult social care agendas.

The partnership approach should provide better value for money over the medium-long term on individual adaptations and maximise the annual spend of the Disabled Facilities Grant and associated Housing Revenue Account.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes.

If so, what is the amount that is allocated for theses discretionary uses and how many districts use this funding?

We accept referrals from HEET, (a local not for profit organisation, helping residents to stay warm and healthy at home, save money on fuel bills and save energy & cut carbon emissions) and fund essential maintenance and repair of the homes of vulnerable owner occupiers from the DDFG. This can include replacement boilers and windows, roof and plumbing repairs and measures to ensure home safety.

Equality and health inequalities

Last year we worked with the Sir Michael Marmot Institute of Health Equity to conduct a thorough review of health inequalities in the borough and to agree a set of actions that will reduce the differences in health outcomes between different population groups. The final report was published in December 2022 and contains over 80 recommendations for partners across the whole system in Waltham Forest. Four accelerator areas have been identified for early action which are: Good work, better health, Healthier homes for private renters, Family hubs at the heart of a healthy life and Community powered healthcare.

The report will inform everything we do in the health area, ensuring that all of our work reduces inequality and allows all our residents to thrive. The actions were developed with partners across the system and are in-line with NHS Priorities and Operational Guidance. They are primarily focused around the social determinants of health such as housing, education, poverty, employment and access to green space. We will also follow the Core20PLUS5 approach, prioritising the most deprived residents, ethnic minority communities and other socially excluded groups.

The population of Waltham Forest is growing. According to the 2021 census, its population is now 278,400 residents, an increase of 7.2% since 2011. These residents form a total of 102,900 households, a 7.8% increase since 2011.

The population is expected to increase by 4.1 percent by 2026 with this growth unevenly distributed between age groups, leading to an aging population, which in turn will lead to increased demand and spending on health and social care services and more demand on services provided by the VCFSE sector. There are also economic impacts, with a lower proportion of the population of working age.

Waltham Forest is one of London's most diverse boroughs and the majority of its population is from minority ethnic backgrounds. The 2021 census estimated 47% of Waltham Forest

residents are from an ethnic minority background, including 20% who are Asian, 15% who are Black and 6% who are mixed race.

Despite having roughly average health compared with England, there are large inequalities in health within Waltham Forest – a 7.6 year difference in life expectancy between wards for women and 6.2 years for men, closely related to level of deprivation of the wards. Chapel End ward had the highest life expectancy over the period 2016–20, at 88.4 years compared with 80.8 for women in Lea Bridge ward, a difference of 7.6 years. Hale End and Highams Park and Chingford Green wards have the highest male life expectancy, 83.6 and 82.7 years respectively, compared with 77.3 years in Hoe Street. Eight wards have lower male life expectancy than the average for England, and two wards have lower life expectancy for women.

The proportion of adults classified as overweight or obese in Waltham Forest is just under the average for London and about average compared with statistical neighbours. While rates are roughly the same as the average for London, they remain high with 54% of adults classified as overweight or obese in Waltham Forest in 2020/21. There are inequalities related to deprivation in rates of overweight or obese, and for children in year 6, rates are higher than the English average and there is considerable difference across the borough. Chingford has relatively low rates at 28.8 percent compared with 45.2 percent in Cann Hall. As across England, there is an association between rates of obesity and deprivation in Waltham Forest. Our new obesity strategy, published in January 2023 for the next five year period, sets out how we plan to focus our efforts on groups most likely to be living with overweight and obesity, including a school 'superzone' programme to focus resources on schools with the highest need in terms of deprivation, obesity levels and other factors.

Across England there is a clear relationship between socioeconomic position and smoking, with smoking rates much higher among those in routine and Manual occupations. Inequalities in smoking prevalence related to employment type are very clear in Waltham Forest, with rates among those working in manual occupations roughly four times higher than those in occupations classified as managerial and professional.

Alcohol consumption increased during the first COVID-19 lockdown and subsequent analysis shows that alcohol-related deaths also increased. Analysis also shows the increase in drinking was in high-risk drinkers – the households already purchasing the highest amount of alcohol increased their purchases more than 17 times compared to those who purchased the least alcohol. People living in the most deprived areas in England increased their alcohol purchases more than in the least deprived areas.

The 2020 Annual Public Health report 20 Questions Annual Public Health Report _FINAL_.pdf (walthamforest.gov.uk) also highlighted how the impact of COVID-19 disproportionately affected groups including men, older people, people living in more deprived areas and people from minority ethnic backgrounds, and exacerbated existing inequalities. Our recovery plans and health improvement initiatives over the coming years will seek to improve health outcomes for all of those who have experienced the worst outcomes from COVID-19.

Addressing equalities and health inequalities, both in terms of access and outcomes, is a central element of the Better Care Fund Plan going forwards. The extent of inequalities, which were exacerbated by Covid-19, in the Borough have been clearly highlighted in the Institute of Health Equity report 'A Fairer and Healthier Waltham Forest'. We will incorporate its findings as a 'golden thread' through all aspects of our Public Health remit, our Integrated Care Strategy, and make this a core part of shaping our post pandemic BCF 'reset' agenda.

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Waltham Forest
Completed by:	Simone Lozer-Jarrett
E-mail:	Simone.Lozer-Jarrett@walthamforest.gov.uk
Contact number:	2084964940
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Naheed	Asghar	cllr.naheed.asghar@walthamforest.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Chief Participation	Charlotte	Pomery	Charlotte.pomery@nhs.net
	Additional ICB(s) contacts if relevant	Director of Delivery	Sue	Boon	sue.boon@nelft.nhs.uk
	Local Authority Chief Executive	Mr	Martin	Esom	Martin.Esom@walthamforest.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Heather	Flinders	Heather.Flinders@walthamforest.gov.uk
	Better Care Fund Lead Official	Mrs	Simone	Lozer-Jarrett	Simone.Lozer-Jarrett@walthamforest.gov

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	LA Section 151 Officer	Mr	Rob	Manning	rob.manning@walthamforest.gov.uk
	Director of Adult Care and Quality Standards	Mr	Darren	McAughtrie	Darren.McAughtrie@walthamforest.gov.uk

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Waltham Forest

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,362,308	£2,362,308	£2,362,308	£2,362,308	£0
Minimum NHS Contribution	£22,739,320	£24,026,366	£22,739,320	£24,026,366	£0
iBCF	£9,486,387	£9,486,387	£9,486,387	£9,486,387	£0
Additional LA Contribution	£63,300	£63,300	£63,300	£63,300	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,329,977	£1,352,054	£1,329,977	£1,352,054	£0
ICB Discharge Funding	£1,205,000	£1,225,003	£1,205,000	£1,225,003	£0
Total	**£37,186,292**	**£38,515,418**	**£37,186,292**	**£38,515,418**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£6,461,870	£6,827,611
Planned spend	£15,503,328	£16,403,328

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,146,659	£7,551,160
Planned spend	£7,347,992	£7,735,038

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	149.0	176.0	174.0	172.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,275.0	1,249.5
	Count	351	343.98
	Population	28584	30670

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.6%	95.5%	95.3%	95.5%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	423	516

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Waltham Forest

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	3.2 Demand – Community 'Reablement at home' is based on 2-year trend in the demand for reablement services. Between 2021-22 and 2022-23, this averaged about 120 per month. 'Other short-term social care', which includes community and hospital discharge, is based on 2022-23 short-term residential and nursing care outturns. Between 2021-22 and 2022-23, this averaged about 80 per month.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! | Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Social support (including VCS) (pathway 0)	11	13	13	15	15	15	15	15	16	15	15	15
BARTS HEALTH NHS TRUST		549	654	637	768	794	784	790	808	776	773	792	774
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		42	49	47	55	55	55	55	57	60	55	45	55
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Reablement at home (pathway 1)	2	2	2	2	2	2	2	2	2	2	2	2
BARTS HEALTH NHS TRUST		68	81	77	77	73	73	72	75	74	90	71	72
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		11	13	13	13	12	12	12	12	12	15	12	12
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
BARTS HEALTH NHS TRUST		17	15	11	18	5	10	5	8	6	2	8	9
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	1	2	2	2	2	1	0	0	2
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
BARTS HEALTH NHS TRUST		17	15	11	18	5	10	5	8	6	2	8	9
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	1	2	2	2	2	1	0	0	2
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Reablement in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
BARTS HEALTH NHS TRUST		9	11	9	6	7	6	6	6	7	6	6	6
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	0	0	0
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
BARTS HEALTH NHS TRUST		9	11	9	6	7	6	6	6	7	6	6	6
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	0	0	0
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	1	1	1	1	1	1	1	1	1	1	1	1
BARTS HEALTH NHS TRUST	(pathway 3)	9	15	9	7	9	9	9	13	16	15	15	16
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		2	2	2	2	2	2	2	2	2	2	2	2

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	100	100	100	100	100	100	100	100	100	100	100	100
Urgent Community Response	113	113	113	114	114	114	110	110	110	112	112	112
Reablement at home	120	115	120	125	110	120	125	120	90	110	105	85
Rehabilitation at home	110	110	110	110	110	110	110	110	110	110	110	110
Reablement in a bedded setting	6	5	5	5	5	6	6	7	7	8	8	7
Rehabilitation in a bedded setting	28	28	28	28	28	32	32	32	32	32	32	32
Other short-term social care	85	90	95	90	85	80	75	75	75	80	80	80

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
														ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	609	725	705	848	875	864	870	890	862	852	861	854			
Reablement at Home	Monthly capacity. Number of new clients.	82	97	93	93	88	87	87	90	89	109	86	87			
Rehabilitation at home	Monthly capacity. Number of new clients.	18	15	11	19	7	12	7	10	7	2	9	11			
Short term domiciliary care	Monthly capacity. Number of new clients.	18	15	11	19	7	12	7	10	7	2	9	11			
Reablement in a bedded setting	Monthly capacity. Number of new clients.	10	12	9	7	8	7	7	7	7	7	7	7			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	10	12	9	7	8	7	7	7	7	7	7	7			
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	11	19	12	10	13	13	12	17	20	19	18	19			

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
														ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	100	100	100	100	100	100	100	100	100	100	100	100			
Urgent Community Response	Monthly capacity. Number of new clients.	113	113	113	114	114	114	110	110	110	112	112	112			
Reablement at Home	Monthly capacity. Number of new clients.	125	130	100	135	120	130	135	130	100	120	115	95			
Rehabilitation at home	Monthly capacity. Number of new clients.	90	90	90	90	90	90	90	90	90	90	90	90			
Reablement in a bedded setting	Monthly capacity. Number of new clients.	9	9	9	9	9	9	9	9	9	9	9	9			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	28	28	28	28	28	28	32	32	32	32	32	32			
Other short-term social care	Monthly capacity. Number of new clients.	95	100	105	100	95	90	80	80	90	90	90	90			

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Waltham Forest

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Waltham Forest	£2,362,308	£2,362,308
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,362,308**	**£2,362,308**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Waltham Forest	£1,329,977	£1,352,054

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North East London ICB	£1,205,000	£1,225,003
Total ICB Discharge Fund Contribution	£1,205,000	£1,225,003

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Waltham Forest	£9,486,387	£9,486,387
Total iBCF Contribution	**£9,486,387**	**£9,486,387**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Waltham Forest	£63,300	£63,300	Social Prescribing
Total Additional Local Authority Contribution	**£63,300**	**£63,300**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North East London ICB	£22,739,320	£24,026,366
Total NHS Minimum Contribution	**£22,739,320**	**£24,026,366**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding

Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£22,739,320**	**£24,026,366**	

	2023-24	2024-25
Total BCF Pooled Budget	**£37,186,292**	**£38,515,418**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Waltham Forest

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,362,308	£2,362,308	£0	£2,362,308	£2,362,308	£0
Minimum NHS Contribution	£22,739,320	£22,739,320	£0	£24,026,366	£24,026,366	£0
iBCF	£9,486,387	£9,486,387	£0	£9,486,387	£9,486,387	£0
Additional LA Contribution	£63,300	£63,300	£0	£63,300	£63,300	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,329,977	£1,329,977	£0	£1,352,054	£1,352,054	£0
ICB Discharge Funding	£1,205,000	£1,205,000		£1,225,003	£1,225,003	£0
Total	**£37,186,292**	**£37,186,292**	**£0**	**£38,515,418**	**£38,515,418**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,461,870	£15,503,328	£0	£6,827,611	£16,403,328	£0
Adult Social Care services spend from the minimum ICB allocations	£7,146,659	£7,347,992	£0	£7,551,160	£7,735,038	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

60, 61,

									Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	ICES Equipment	Community Equipment Provision	Assistive Technologies and Equipment	Community based equipment		18,000	18,000	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£592,074	£592,074	20%
2	Safeguarding, Adults Protection	Safeguarding, Adults Protection	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£36,500	£36,500	10%
3	Community Based Stroke Service	Stroke Support	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£80,000	£80,000	5%
4	Supported Home Discharges	Discharges	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£482,000	£482,000	3%
5	Community Rehabilitation	Community Rehab	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,316,000	£1,316,000	8%
6	Social Care Assistants to support Home Discharge	SCA Staff	Workforce recruitment and retention						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£260,000	£260,000	2%
7	Home Care packages	Home Care packages	Home Care or Domiciliary Care	Domiciliary care packages		86100	86100	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,550,000	£1,550,000	8%
8	Frequent Attenders Service	Frequent Attenders Service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£143,700	£143,700	1%
9	Psychiatric Liaison	Psychiatric Liaison	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Mental Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,866,000	£1,866,000	12%
10	Neuro Navigator	Neuro Navigator	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Mental Health		NHS			NHS	Minimum NHS Contribution	Existing	£90,434	£90,434	1%
11	Specialist EPIC (EOL Community)	Specialist EPIC (EOL Community)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£516,360	£516,360	3%

12	Dementia Advisory Service	Dementia Advisory Service	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£202,000	£202,000	1%
13	Reablement Core Services	Reablement Core Services	Home-based intermediate care services	Rehabilitation at home (to support discharge)		101500	101500	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,828,000	£1,828,000	10%
14	Rapid Response	Rapid Response	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£3,892,000	£3,892,000	25%
15	Rehabilitatioin Social Workers	Rehabilitatioin Social Workers	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£173,000	£173,000	1%
16	Community Rehabilitation	Community Rehabilitation Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		76	76	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,745,000	£4,745,000	31%
17	Community Falls Service	Community Falls Service	Prevention / Early Intervention	Other	Falls Prevention				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£688,550	£688,550	4%
18	IDH Hub LA	Integrated Discharges Support	Workforce recruitment and retention						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£390,000	£390,000	4%
19	IDH - NHS	Integrated Discharges Support	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£748,434	£748,434	5%
20	Age UK - Just Connect	Age UK - Just Connect	Prevention / Early Intervention	Other	Voluntary Sector Development				Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£112,000	£112,000	1%
21	Extra Care Sheltered Housing	Extra Care Placements	Residential Placements	Extra care		10	10	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£235,000	£235,000	1%
22	MH Placements	MH Complex Placements	Residential Placements	Care home		10	10	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£530,000	£530,000	1%
23	Care Act Placements	Supported Living Placements	Residential Placements	Supported housing		17	17	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£875,418	£875,418	2%
24	GML Step Dwn Beds	GML Step Down Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step		10	10	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	New	£504,000	£504,000	20%
25	CHC Assessment Team	Supporting Assessment Process	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Continuing Care		NHS			NHS	Minimum NHS Contribution	Existing	£700,850	£700,850	5%
26	Carers Contract	Carers Contract	Carers Services	Carer advice and support related to Care Act duties		648	648	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	New	£182,000	£182,000	25%
27	Reablement	24-25 Uplift allocation	Home Care or Domiciliary Care	Domiciliary care packages		50000	50000	Hours of care	Community Health		NHS			NHS	Minimum NHS Contribution	New	£0	£900,000	0%
28	Equipment	24-25 Uplift allocation	Assistive Technologies and Equipment	Community based equipment		1500	1500	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	New	£0	£387,046	15%
29	Additional LA Contribution - Social Prescribing	Social Prescribing	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£63,300	£63,300	25%
30	DFG	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		118	118	Number of adaptations funded/people	Primary Care		LA			Local Authority	DFG	Existing	£2,362,308	£2,362,308	100%
31	Improved Better Care Fund	Better Mental Health	Residential Placements	Care home		36	36	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£1,903,900	£1,903,900	4%
32	Improved Better Care Fund	Better Mental Health	Workforce recruitment and retention						Social Care		LA			Local Authority	iBCF	Existing	£55,000	£55,000	1%
33	Improved Better Care Fund	Better Mental Health	Residential Placements	Supported housing		8	8	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£440,000	£440,000	1%
34	Improved Better Care Fund	Improving Life Chances for people with Learning Disabilities	Residential Placements	Learning disability		23	23	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£1,772,300	£1,772,300	3%
35	Improved Better Care Fund	Promotong Wellbeing - Early Intervention & Prevention	Workforce recruitment and retention						Social Care		LA			Local Authority	iBCF	Existing	£557,000	£557,000	5%
36	Improved Better Care Fund	Promotong Wellbeing - Early Intervention & Prevention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	iBCF	Existing	£115,000	£115,000	50%

37	Improved Better Care Fund	Promotong Wellbeing - Early Intervention & Prevention	Prevention / Early Intervention	Other	Voluntary Sector Development				Social Care		LA			Local Authority	iBCF	Existing	£184,000	£184,000	25%
38	Improved Better Care Fund	Management of Care Market	Residential Placements	Care home		28	28	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£1,450,000	£1,450,000	3%
39	Improved Better Care Fund	Prevention and Early Intervention	Assistive Technologies and Equipment	Community based equipment		250	250	Number of beneficiaries	Social Care		LA			Private Sector	iBCF	Existing	£408,900	£408,900	15%
40	Improved Better Care Fund	Home Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		93100	93100	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£1,675,887	£1,675,887	8%
41	Improved Better Care Fund	Intermediate Bed Based Support	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step		5	5	Number of Placements	Social Care		LA			Local Authority	iBCF	Existing	£55,000	£55,000	10%
42	Improved Better Care Fund	Enabling Support	Enablers for Integration	Programme management					Social Care		LA			Local Authority	iBCF	Existing	£60,000	£60,000	10%
43	Improved Better Care Fund	Staffing and Support Structures	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	iBCF	Existing	£435,000	£435,000	4%
44	Improved Better Care Fund	SL Care Placements	Residential Placements	Supported housing		9	9	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£374,400	£374,400	1%
45	LA Discharge Fund - Support Packages	Supporting Hospital Discharges	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		73900	73900	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£1,329,977	£1,352,054	7%
46	ICB Discharge Fund - Support Packages	Supporting Hospital Discharges	Residential Placements	Care home		13	13	Number of beds/Placements	Social Care		LA			Local Authority	ICB Discharge Funding	Existing	£822,654	£842,657	2%
47	ICB Discharge Fund - Bridging Service	Supporting Hospital Discharges	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		21400	21400	Hours of care	Community Health		NHS			NHS	ICB Discharge Funding	Existing	£382,346	£382,346	0%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Waltham Forest

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	191.5	173.3	180.8	172.0	The indicator values for 2023-24 are the previous targets from last year that have been rolled over as a continued ambition. The lastest data set was reviewed and existing targets were not met in 22-23. Therefore it would be realistic to contiune with previous targets as this still shows an ambition for improvement.	As part of the Home First transformation programme there is focussed work around admission avoidance. Over 2023/25 we will implement an integrated assessment function to carry out community assessment and urgent care response. We will be recruiting additional 5.9 WTE staff in 2023/24 to expand Rapid Response. In addition, we will be expanding virtual ward
	Number of Admissions	412	373	389	-		
	Population	276,983	276,983	276,983	276,983		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	149	176	174	172		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,604.0	1,275.0	1,249.5	The latest baseline data was reviewed in conjunction with local schemes to provide an improvement for 23-24 based on the estimated 2022-23 data.	There are two services which address community falls to avoid admission into hospital. These are the Falls Prevention service which offer up to 12 weeks of targetted support to residents and the falls pick up service which is part of Rapid Response. During 2023/25 we will be reviewing our urgent care falls response to
	Count	445	351	343.98		
	Population	28,584	28584	30,670		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are	Quarter (%)	95.1%	95.0%	94.9%	94.6%	The 2023-24 plan is based on trends from the last 12 months of activity, which does show average increases in overall acute hospital activity (denominator). The	Throughout 2023/25 we will continue to build off our Home First D2A approach. Our current fortnightly reporting as part of the adult social care discharge fund and
	Numerator	4,447	4,469	4,475	3,453		
	Denominator	4,677	4,704	4,717	3,651		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan	hospital activity (denominator). The number and proportion of patients being discharged to their normal place of residence has accelerated in 2022-23. and this reflected in line with local plans and ambitions.	adult social care discharge fund and monthly reporting to the Home First Executive and Waltham Forest Health and Care partnership reports on discharge destination across pathways including the number of people discharged home to their normal place of residence. Specific actions
	Quarter (%)	95.6%	95.5%	95.3%	95.5%		
	Numerator	4491	4514	4520	4,508		
	Denominator	4700	4728	4741	4,723		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	422.9	491.4	494.6	516.3	2023-24 projection based on 2 year trend in 65+ residential and nursing admissions (a trend we anticipate will continue) and return to pre-pandemic levels (169 people in March 2019). Net increase of 12 residential placements and reduction of 27	System will continue to ensure residents can return home to live independently using Home First principles including reablement, interim placements and home based support with the aim of a smaller percentage of people in long term
	Numerator	129	155	156	166		
	Denominator	30,507	31,540	31,540	32,155		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.8%	91.3%	86.5%	87.1%	2023-24 plan is based on the 3 year trend projection in 65+ hospital discharge. We anticipate the trend of lower mortality rates to continue and the outcome measure to improve closer to pre-pandemic levels, despite the challenges	To maximise the number of P1 discharges via the universal reablement offer – a key part of the Home First approach – rather than returning to the pre-pandemic service criteria. Plans to re-commission the personal care element to create a more
	Numerator	173	158	179	195		
	Denominator	204	173	207	224		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Waltham Forest

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes				Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes
Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

North East London Health & Care Partnership

NHS North East London

23/24 Operating plan, Final submission summary – place partnerships

Author – Sunil Thakker, Director of Finance

Presented by – Sunil Thakker, Director of Finance

Monday 7 November 2022 Waltham Forest Health and Care Partnership Board

Executive Summary / Summary of Key Issues:	Purpose of Paper / Ask of the Board:
• The paper outlines NEL ICS's 23/24 Operating Plan • This includes the 23/24 NHS Priorities, national objectives and key targets • This is further analysed by programme spend, provider updates, workforce and finance positions	The Waltham Forest Health and Care Partnership Board is asked to: Note the attached 23/24 Operating Plan
Engagement:	**Specific Risks:**
• The paper has been discussed and approved at both FPIC and ICS Board	• Specific risks outlined in the plan relate to achievement of savings, ERF and delivery targets

NHS
North East London

23/24 Operating plan

Final submission summary – place partnerships

23/24 NHS priorities

Recovering our core services and productivity	Delivering the key NHS Long Term Plan ambitions and transforming the NHS	Continue transforming the NHS for the future	Local empowerment and accountability
• Improve ambulance and A&E waiting times • Reduce elective long waits and cancer backlogs, and improve performance against core diagnostic standards • Make it easier for people to access primary care services, particularly in general practice	• Improve mental health services and services for people with a learning disability and autistic people • Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services • We need to put the workforce on a sustainable footing for the long term • To level up digital infrastructure and drive greater connectivity		• ICSs are best placed to understand population needs and are expected to agree specific **local objectives that complement the national NHS objectives** • They should continue to pay due regard to wider NHS ambitions in determining their local objectives – alongside place-based collaboratives

2023/24 national objectives and key targets

Urgent and emergency care
- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
- Reduce adult general and acute (G&A) bed occupancy to 92% or below

Community health services
- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Virtual Ward – 40 – 50 per 100,000 by December 2023, and occupancy at 80% by September 2023
- Community waiting list reduction
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals

Primary Care
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic level

Elective care
- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Deliver the system- specific activity target (agreed through the operational planning process)
- Value weighted elective activity target (as a % of 2019/20)–excludes secondary dental 109%
- Reduce outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- To increase productivity and meet the 85% day case and 85% theatre utilisation expectations

Cancer
- Continue to reduce the number of patients waiting over 62 days
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

Diagnostics
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

Maternity
- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
- Increase fill rates against funded establishment for maternity staff

Mental Health
- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- Increase the number of adults and older adults accessing IAPT treatment
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Work towards eliminating inappropriate adult acute out of area placements
- Recover the dementia diagnosis rate to 66.7%
- Improve access to perinatal mental health services

Use of resources
- Deliver a balanced net system financial position for 2023/24

People with a learning disability and autistic people
- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
- Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit

Prevention and health inequalities
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

Workforce
- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

Ongoing CHS LTP priority commitments across 2023/24

Putting people in control of their own care through more personalisation

(Government Mandate to the NHS, 22/23)

Growth and development of integrated neighbourhood teams to support our most vulnerable and complex patients to stay at home and access care in the community

(Fuller Stocktake)

Deliver an additional 2,500 Virtual Ward (VW) beds, effectively utilised both in terms of addressing the right patient cohort and optimising referrals.

(NHS Winter Letter)

Actively consider establishing an Acute Respiratory Infection (ARI) hub to support same day assessment

(NHS Winter Letter)

Putting in place a community-based falls response service in all systems for people i.e. who have fallen at home including care homes

(NHS Winter Letter)

Ensuring that patients receive personalised care tailored to their individual needs

(NHS Standard Contract 22/23)

Comply with the new statutory duty for ICBs to commission palliative and end of life care services in response to population needs, drawing upon NHSE statutory guidance.

(Palliative and end of life care: Statutory guidance for integrated care boards (ICBs))

Shift more care to the community, including safe and convenient care at home or close to home, through developing the capacity and capability of community health services, integrated neighbourhood teams and new models of care

(NHS England operating framework)

Strengthen the hands of the people we serve through the comprehensive model of personalised care including supporting people to have increased choice and control over their care based on what matters to them as well

(NHS England operating framework)

2023/24 national objectives and key targets

Area	23/24 Key Target	23/24 plan compliance
Urgent and emergency care	1. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 2. Reduce adult general and acute (G&A) bed occupancy to 92% or below	1. Meets target 2. Meets target
Elective care & Diagnostics	1. Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) 2. NELs overall elective activity (EL + DC + Total Outpatient First) trajectory is 106.5% compared to 2019/20, Barts trajectory is 106.2%, Homerton trajectory is 100.5% and BHRUT trajectory is 109.6%. 3. Reduce outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024 4. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	1. Meets target 2. Meets target 3. Not compliant 4. Meets target
Cancer	1. Continue to reduce the number of patients waiting over 62 days 2. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days 3. Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	1. Meets target 2. Meets target 3. Meet target
Community health services	1. Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard 2. Virtual Ward – 40 – 50 per 100,000 by December 2023, and occupancy at 80% by September 2023	1. Meets target 2. Partially meet target (deliver 40 per 100,000 in March)
Primary Care	1. Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic level	1. Not compliant
Mental Health	1. Inappropriate Out of Area Placement Bed Days 2. Access to IAPT Services 3. Estimated dementia diagnosis rate 4. Women accessing Perinatal Mental Health services 5. Community access for adults with SMI 6. Access to CYP services	1. Meets target 2. Not compliant 3. Meets target 4. Not compliant 5. Meets target 6. Not compliant
People with a learning disability and autistic people	1. Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 2. Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	1. Meets target 2. Meets target

Executive summary 1/2

Elective and diagnostics

- 109% ERF achieved.
- Homerton Healthcare expected to clear all waits over 65 weeks by end of July 2023
- Barts Health and BHRUT expect to clear all waits over 65 weeks end of March 2024
- Activity levels in our diagnostic modalities exceed 100% of BAU, and our 23/24 plans will continue to sustain this, with the exception of endoscopy where we have successfully recovered the waiting list position and demand has reduced.

Cancer

- NEL is required to achieve a backlog of below 7% in aggregate (patients waiting over 62 days by March 2024), currently the backlog is 7.4%. NEL have submitted a trajectory that will meet the target through target pathway approach and enhancing validation of long waiters.
- NEL have submitted a compliant trajectory against 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days through utilisation, and expansion of early diagnostic centres, improving referrals for FIT testing, Teledermatology will continue in Barts Health and BHRUT.
- NEL have submitted compliant trajectories for early diagnosis through prevention awareness and screening (key programmes include targeted lung health check, targeted awareness and focusing on key demographics and hard to reach groups; with a specific focus on reducing inequality). Additional initiatives spans across our diagnosis and treatment workstream to ensure timely access and treatment including via non-traditional pathways such as piloting self and pharmacy direct referrals.

Urgent and emergency care

- All our Trust have submitted compliant trajectories to deliver 76% standard by March 2024. Homerton is the only Trust that is currently compliant and therefore will be a stretching target to achieve for Barts Health and BHRUT particularly. There are various schemes around admitted and non-admitted pathways across our sites to support delivery of this target.
- Additional capacity funding has been approved by NHSE which build additional bed capacity in our hospitals to support delivery of the bed occupancy and A&E targets.

Community services

- NEL continue to submit to deliver on the 70% UCR contacts within 2 hours and have sustained this performance in 23/24 trajectories. Further work is being undertaken to increase referrals through UCR to support with front door pressures.
- Virtual Ward currently at 23 bed per 100,000. The trajectory for 23/24 is 30 beds from April to December and deliver the target of 40 by March 2024. This will be a stretching target, however a key area of focus for the community collaborative.
- There are not targets set for community waiting lists, however the main concern for NEL is Children Services as 54% seen within 18 weeks with 46% seen over 18 weeks. The community collaborative agreed that speech and language is an area of focus and deep dive which is the driver of the longest waits.

Executive summary 2/2

Primary Care

- NEL GP appointments will increase by an average of 3% in 23/24 compared to 22/23. GP Appointment numbers have been derived by looking at the borough level population increase projections and then applying these to appointment activity data (for 2022), patient turnover will remain at a similar level which is as high as 30% churn in some neighbourhoods. Although we have not set targets for each place we will provide continued support will be given to local systems to understand variation and inequalities through reviewing performance including data and coding at a practice level. This will inform development of local pathways in and out of primary and urgent care to scope the needs of local patient cohorts.
- The recovery plan for Dentistry is iterative on the basis that many of the issues that affect access to dentistry are centred around the current contract and we have no ability to amend or flex this. That said, one aspect is the ability to allow practices to overperform up to 110% where capacity allows and remunerate them accordingly. Practices are contractually obliged to achieve 96% of their contracted activity to avoid the resource associated with underperformance being 'clawed back.

Mental Health and Learning Disability

- IAPT and perinatal mental health non-compliant trajectory - Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures.
- CYP - CYP Urgent Care expansion is not predicted to increase access, some places need to expand duration of treatment to meet rising acuity, however this will not increase access.

Finance

- NEL system finance plan submitted to show a system breakeven position .
- Within the overall breakeven plan, Barts have a deficit, BHRUT and Homerton are close to breakeven and the ICB, ELFT and NELFT are all delivering a surplus to offset the deficit.
- The ICB planned surplus is £15.4m.
- The plan includes a significant level of risk at £209.5m that is currently unmitigated
- Capital plan will be financially compliant, however, the level of funding is not sufficient to meet all NELs needs and will be working with London to seek additional funding in year.

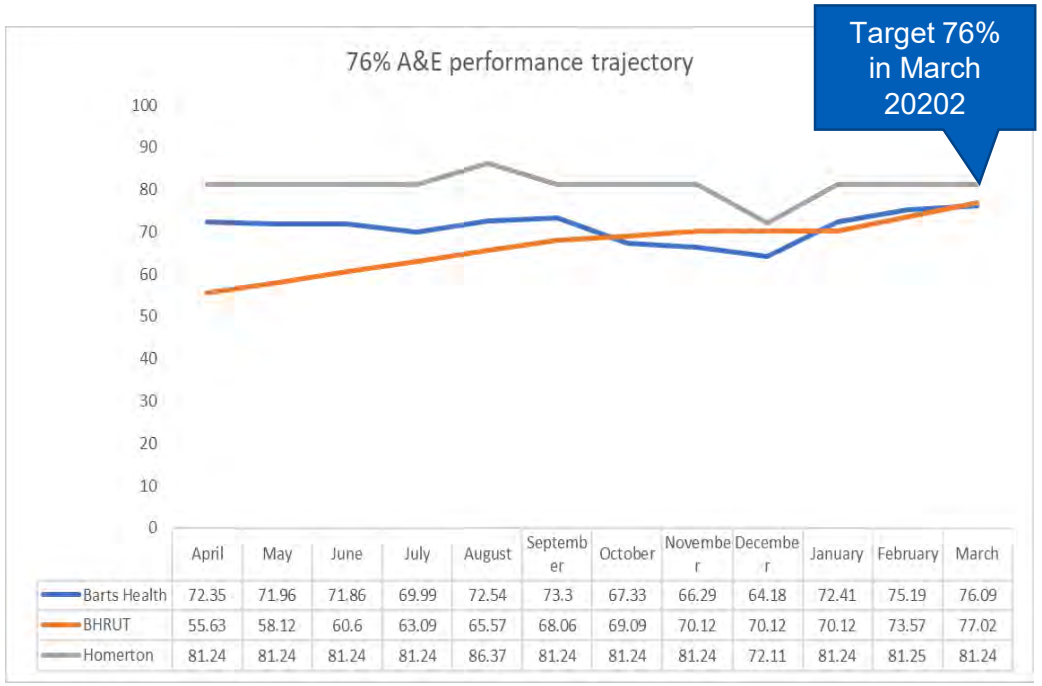
23/24 NEL ICB Elective Summary from Final Op Plan Submission

Area / Metric	Objective / Target	Position as per Final Submission
Inpatients - Long Waiters Elimination / Reduction	Eliminate waits of over 65 weeks for elective care by March 2024	🟢 All Trusts are expecting to deliver the 65 week wait time reduction requirements for 23/24.
	Reduce 52 ww	🟢 All Trusts are showing a trajectory that reduces 52ww across the year.
Activity Increase	Delivery of around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance	🟢 NELs overall elective activity (EL + DC + Total Outpatient First) trajectory is 106.5% compared to 2019/20, Barts trajectory is 106.2%, Homerton trajectory is 100.5% and BHRUT trajectory is 109.6%.
Outpatient Follow-Up Reduction	Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024	🟡 25% reduction in outpatient follow-up will not be achieved across all follow-up activity given size of backlog and impact of mutual aid, NEL trajectory is 103% compared to 2019/20. Barts Health are the only trust with a trajectory over 100% compared to 2019/20 at 106%, the Trust has revised the position down from 117% in the draft submission. BHRUT trajectory is 97% and Homerton Trajectory is 99%.
PIFU / A&G	** No specific ask in guidance **	PIFU and A&G trajectories build on performance seen in 2022/23, however room for improvement.
Productivity - Theatre Utilisation & Daycase	Increase productivity and meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings	🟢 The system is on track and planning to achieve the 85% theatre utilisation target with plans to improve waste through reducing late starts, early finishes, cancellations and fallow sessions.
	Increase productivity and meet the 85% day case expectations, using GIRFT and moving procedures to the most appropriate settings.	🟢 The system is on track and planning to increase daycase rates to the 85% target.
Diagnostics - Activity Increase & 6ww	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	🟢 Increased diagnostic activity compared to 2019/20 will not be achieved in endoscopy given success in clearing the backlog and current levels of demand. Activity is over at or 100% for all modalities, except flexi sigmoidoscopy which is 60.6%.
	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	🟢 NEL appears to be on track to achieve 95% 6 week diagnostic test ambition by March 2025, with MRI being the only real risk.

Cancer

How will your system reduce the number of patients waiting over 62 days in line with the provider level requirements? **23/24 meets target**	• NEL is required to achieve a backlog of below 7% in aggregate (patients waiting over 62 days by March 2024). Currently the backlog is 7.4%. • Targeted pathway approach in urology (access to MRI & TP biopsy), H&N (outpatient capacity and ENT calculator), LGI (appropriate escalation of pathology turnaround times and endoscopy capacity), Skin (tele-dermatology with one stop excision following triage). • Ongoing weekly APG meetings with providers, Cancer Alliance, ICB supported by the Centre for Cancer Outcomes (CCO). • Administrative support- developing a central operational project support for MDT with flexibility to support more challenged tumour areas when required by the system. The team will additionally support validation. • Enhancing validation resource, working with the independent sector and system wide solutions (including working with other programmes and networks such as Elective and diagnostic programmes) are some of the mechanisms that will be used. • Enhancing our visibility- Development of a single North East London Cancer digital PTL.
How will your system meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days? **23/24 meets target**	• The system will continue to utilise the Early and community Diagnostic Centre and will expand the capacity across other modalities to meet expected levels of growth. • Expansion of the diagnostic capacity through the CDC programme. • The system will maintain the pathway changes for lower GI to include (referrals with a FIT test). • The use of teledermatology will continue at BHR and BH with the support of the Cancer Alliance. Whilst the system explores the use of AI technologies to further manage the demand challenges on the skin pathway. Insourcing at Homerton solutions will be used to facilitate the management of demand at HUH. • The Cancer Alliance will continue working with providers to implement and strengthen best practice times pathway. With a focus on those performing below the England FDS
How will your system increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028? **23/24 meets target**	The current proportion of cancer stage 1 and stage 2 at diagnosis is 55%. This is linked to socio- economic determinants of health in North East London. Therefore the scale of the challenge to achieve 75% is significant for North East London. There is multi pronged approach to increase the proportion of stage 1 and stage 2 cancers. This encompasses prevention awareness and screening (key programmes include targeted lung health check, targeted awareness and focusing on key demographics and hard to reach groups; with a specific focus on reducing inequality). Additional initiatives spans across our diagnosis and treatment workstream to ensure timely access and treatment including via non traditional pathways such as piloting self and pharmacy direct referrals. We are also expanding our RDC non site specific pathways in addition to ensuring rapid and direct access to diagnostics for primary care to our CDCs/EDC.

Urgent and emergency care - A&E



	April	May	June	July	August	September	October	November	December	January	February	March
Barts Health	72.35	71.96	71.86	69.99	72.54	73.3	67.33	66.29	64.18	72.41	75.19	76.09
BHRUT	55.63	58.12	60.6	63.09	65.57	68.06	69.09	70.12	70.12	70.12	73.57	77.02
Homerton	81.24	81.24	81.24	81.24	86.37	81.24	81.24	81.24	72.11	81.24	81.25	81.24

It is recognised that achievement of the 76% performance standard is ambitious and that there is currently variation in performance among the Acute Provider Collaborative sites. Plans have been developed to achieve this requirement with initiatives being undertaken including:-

BHRUT

Overall BHRUT expects a reduction in total time for time spent in A&E due to the below points:

- **Non-admitted** Expanding SDEC footprint at Queens ED & KGH will improve Type 1 performance through progressing patients quickly through RAFT and onto SDEC pathway
- **Non-admitted** Redesign of UTC to ED Pathways at KGH, following Queens ED approach, will ensure only patients meeting ED right to reside criteria are referred to ED with direct route to SDEC
- **Admitted** Clinical productivity review aligned to clinical workforce rightsizing ensure that clinical hours are matched to demand and metrics set on number of patients to be seen by hour

Barts Health

- Further development of our SDEC capacity and operating models across the 3 sites to improve the use of ambulatory and same day emergency care pathways
- Sustain our REACH programme, review the streaming and Urgent Treatment Centre models and develop same day primary care access hubs
- Each site within Barts Health has a High Intensity user services
- Launch of Frailty and Respiratory Virtual Wards

Mental Health

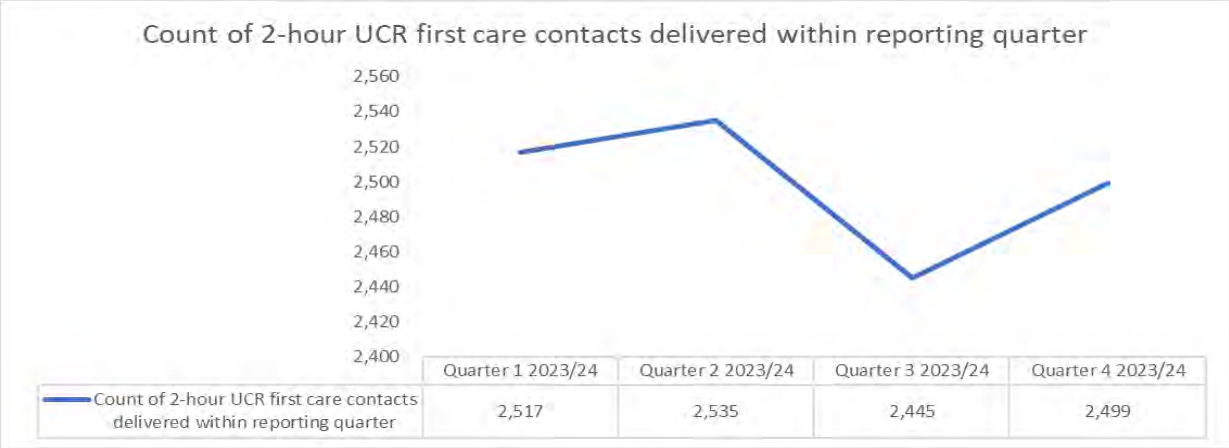
- Optimising flow through NEL inpatient services and improve availability of beds, thus reducing A&E breaches
- Improving the liaison offer available within A&Es, and responsiveness for assessment
- Increasing CDU capacity

Urgent and emergency care – additional capacity

Additional funding was made available nationally above and beyond ICB allocations, London has £47.2m in 23/24 to invest in additional G&A bed capacity to address the UEC challenge in London. North East London received the following:

Site - where relevant	Narrative	Increase in beds	Capital	Cost 2023/24	Full year recurrent cost
King George Hospital	Enhanced SDEC / safe area for mental health patients awaiting onward transfer (16 beds/spaces)	16	£2,000	£ 375	£ 1,500
Queens Hospital 1	Surgical assessment unit (12 trolley spaces)	12	£3,000	£ 498	£ 1,000
Queens Hospital 2	Revenue support to optimise use of 12 bed Ambulance offload Modular Unit	12	£0	£ 996	£ 1,000
Homerton Hospital 1	Defoe Ward: continued winter scheme to ensure safe staffing levels are maintained on Defoe (escalation ward) whilst it remains open for the foreseeable.			£ 966	£ 1,933
Barts Health	62 G&A beds across Barts Health sites	62	£554	£ 3,000	£ 3,000
Whipps Cross Hospital	This is the setting up of a 10 chaired/bedded surgical SDEC model to avoid up to 12 admissions per day (20 admission x 60% success)	10	£1,550	£ 12	£ 12
Total		**112**	**£7,104**	**£ 5,847**	**£ 8,445**

Urgent community response



	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Count of 2-hour UCR first care contacts delivered within reporting quarter	2,517	2,535	2,445	2,499

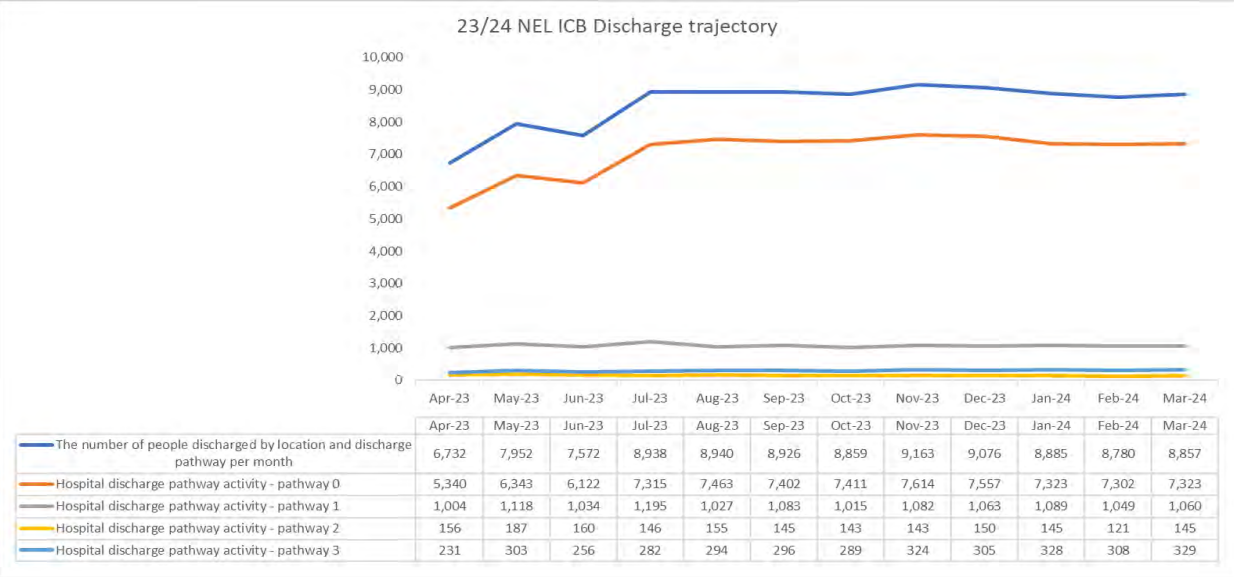
Further opportunities:

- A pilot was undertaken between LAS and NHS NEL to increase referrals from 111 and 999 through a push model with dedicated staff within the LAS call centres to increase referrals to our UCR services; this pilot did increase 111 and 999 referrals. The NEL Community Collaborative leaders oversee the review of learning from our pilot and from elsewhere in London to ensure our UCR models are optimal for NEL. Our next pilot will aim to both increase 111 and 999 referrals and help us to understand our local flows and potential for increasing referrals through this pathway.
- The Community collaborative is exploring the impact of delivering more than the national expectation of 70% contacts in 2 hours.
- Also exploring increasing referrals to UCR to support the wider system and A&E and unplanned admissions.

NHS NEL constantly meets and exceeds the 2-hour response time, the service is open 7 days a week across the core hours of 8am to 8pm covering the 9 core clinical conditions. Across NHS NEL the following is in place for UCR:

- The services consistently meet and exceeds the 2-hour response time and the services are open 7 days a week across the core hours of 8am to 8pm.
- The services meet the 9 core clinical conditions, as well as a wider range, this includes falls which are integrated.
- Existing pathways are in place with telecare (pendant alarm for example), 111, London Ambulance and other health teams such as A&E.
- Single points of access are in place.
- As with every winter services are reviewed and supported to ensure that it has sufficient capacity in place for changes in demand.
- NEL UCR services have a well-established self-referral pathway, which is well known to patients already under community health services and we have a direct pathway with Primary Care teams with further work happening to increase self-referrals where variation exists currently.
- A pathway with the Remote Emergency Access Coordination Hub (REACH) is in operation in Tower Hamlets, Newham and Waltham Forest which is a joint service between Bart's Health and London Ambulance.
- LAS and NELFT have jointly operated a UCR car across Barking and Dagenham, Havering and Redbridge since 2016 and the model has been expanded to two cars in Q4 2022/23 using LAS winter funding.

Discharge pathway



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
The number of people discharged by location and discharge pathway per month	6,732	7,952	7,572	8,938	8,940	8,926	8,859	9,163	9,076	8,885	8,780	8,857
Hospital discharge pathway activity - pathway 0	5,340	6,343	6,122	7,315	7,463	7,402	7,411	7,614	7,557	7,323	7,302	7,323
Hospital discharge pathway activity - pathway 1	1,004	1,118	1,034	1,195	1,027	1,083	1,015	1,082	1,063	1,089	1,049	1,060
Hospital discharge pathway activity - pathway 2	156	187	160	146	155	145	143	143	150	145	121	145
Hospital discharge pathway activity - pathway 3	231	303	256	282	294	296	289	324	305	328	308	329

As a system NEL perform well in discharge; we have seen 9-11% of beds taken up by patients that do not meet the criteria to reside, against 15% nationally.

Some of our challenges have been:

- Capacity in more complex step down services and more complex reablement packages
- High levels of pressure on the urgent care system that put pressure on discharge

Across north east London, all places are working to improve discharge. The aim is to ensure faster discharges and that people are being moved into the correct place to support their needs. Although discharge is place based, the following are the common ambitions across the ICS:

- Encouraging a home first approach
- Continued improvement of the transfer of care hubs
- Promoting independence and reablement

Some of the key work at Place in 23/24:

- City and Hackney: An external evaluation of discharge is currently underway. The output from this will be a shared understanding of successes and challenges across the local system with focus on areas of opportunity. This process will develop a vision for change with a project plan with clear performance targets and a framework to measure performance.
- Tower Hamlets: Development of a single streamlined discharge model moving away from the current 3 team model.
- Newham: Appointing a single Head of Discharge for Newham, managing an integrated team.
- Waltham Forest: Implementing the Home First model including developing integrated rehab and reablement provision.
- In addition, across the Barts Health footprint: Delivery of the recommendations from a recent diagnostic undertaken by Newton Europe. Recommendations include ensuring we have Advance Care Planning, embedding Discharge to Assess, reduction in use of step down bed based provision, improved use of Intermediate Care and using digital tools to ease discharge process.
- Barking and Dagenham, Havering and Redbridge: The three Places that sit within the BHRUT footprint have reviewed reasons for discharge delay and have set up 3 task and finish groups focusing on discharge to assess home, review of the integrated discharge hub and review of rehab pathways.
- Our key risks are: Financial – whilst we welcome the £600m investment in 23/24 it is a step down on current levels of funding and needs to be seen within the context of significant financial pressures in local authorities and Workforce – there are significant challenges in attracting and retaining people within the care sector.

Community waiting list

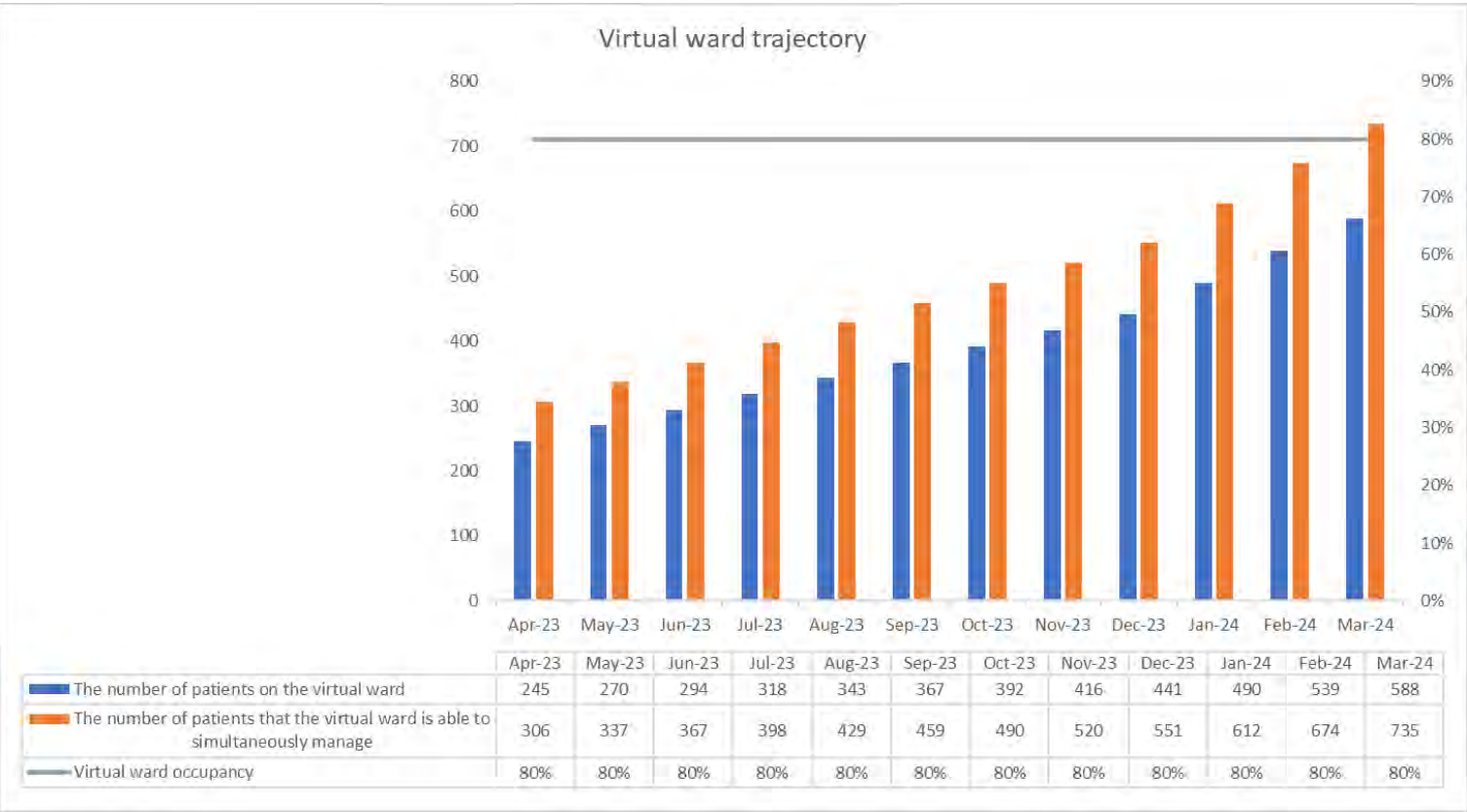
	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Number of CYP (0-17 years) on community waiting lists per system	7502	7316	7131	6950
Number of Adults (18+ years) on community waiting lists per system	13189	12763	12318	11963

Key risks to note:

- Data quality issues in reporting.
- Particular challenges are around children's therapy services across NEL.
- Key issues impacting on waiting list are workforce, estate or demand.
- Data currently being reported by providers to NHSE is only at NEL or provider level, therefore difficult to enable place-based specific improvement discussions.

- In January 2023 for adults 88% were seen and treated within 18 weeks with 12% waiting over 18 weeks. For Children's 54% seen within 18 weeks with 46% seen over 18 weeks.
- The community waiting list is being reviewed and actioned through the community health collaborative and the place based partnerships.
- There are particular issues around data quality and consistency of reporting that is being actioned through the CHC.
- There are particular issues in children's therapy services which are being investigated and will be addressed through the CHC and place based partnerships.
- North-East London has identified that waiting times for Speech and Language Therapies for Children and Young People are significantly long in comparison to other ICB areas.
- The Community Health Collaborative is proposing an exercise be undertaken to identify the current provision delivered in each of the 7 Place-based Partnerships, to allow the sharing of best practice and the opportunity to identify where added value can be brought to these services to increase access.

Virtual ward



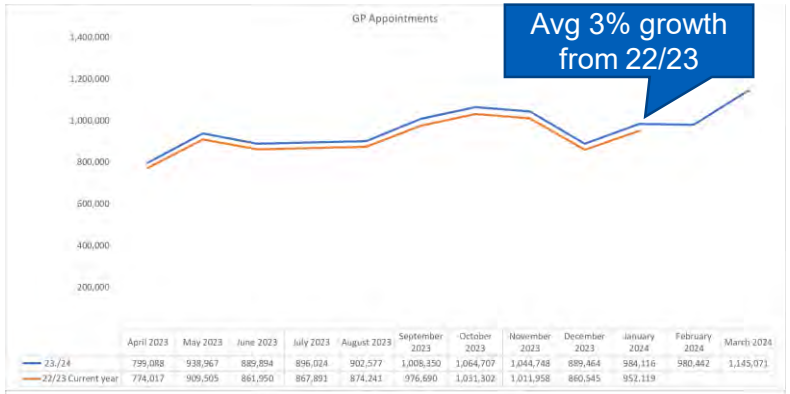
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
The number of patients on the virtual ward	245	270	294	318	343	367	392	416	441	490	539	588
The number of patients that the virtual ward is able to simultaneously manage	306	337	367	398	429	459	490	520	551	612	674	735
Virtual ward occupancy	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

- The current baseline trajectory for virtual wards is based on 23 beds per 100,000 population in 2022/23 and then 30 beds per 100,000 population in Q1 to Q3 2023/24, with the aim of delivering 40 per 100,000 by Q4 March 2024.
- Current capacity stands at 174 beds throughout NEL.
- The control factors for the trajectory of patient numbers are the LOS (14 days) and occupancy levels (80%).
- We are not expecting substantive variances against previously submitted two-year trajectories for virtual ward capacity. However, we continue to have an ambition to grow bed provision in FY 23/24.
- We have taken a population health approach with data and delivery and prioritise our work and funding on areas where there is greatest population need. We will work with system leadership to drive growth of VW in 23/24 including improved links with our wider community services. The two national priority areas, Frailty and ARI are our focus however we are exploring a range of clinical pathways as VW matures including hospice at home, UCR and Care Home interfaces and more opportunities for growth to avoid admissions.
- £8m dedicated funding for virtual ward.

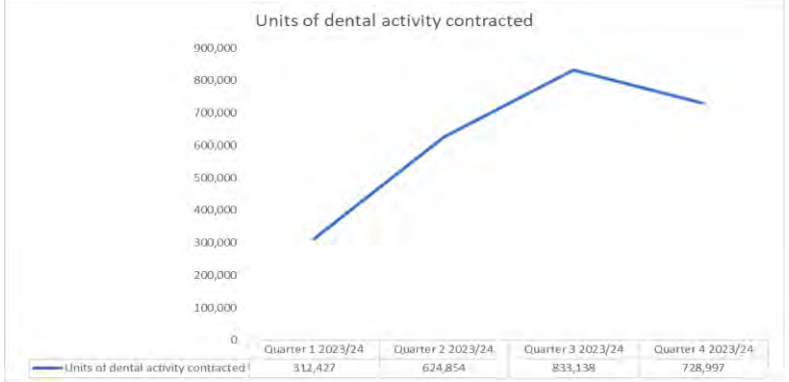
Key risks to note:

- Delivering 40-50 per 100’000 beds across NEL will be stretching.
- Current beds is at 23 per 100’000 and this is at maximum availability, while further work is happening to find additional capacity.

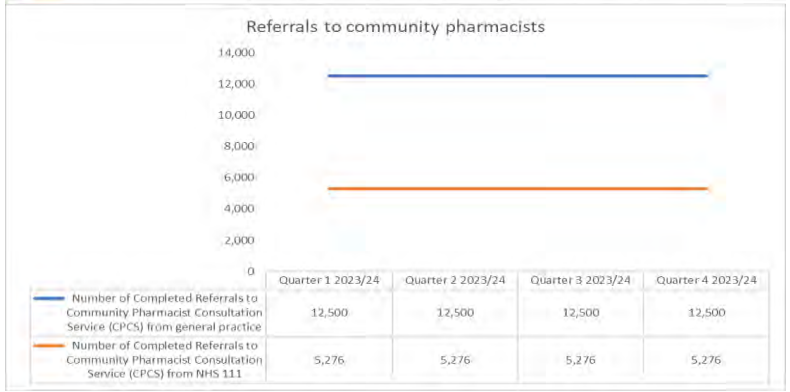
Primary care



	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024
23./24	799,088	938,967	889,894	896,024	902,577	1,008,350	1,064,707	1,044,748	889,464	984,116	980,442	1,145,071
22/23 Current year	774,017	909,505	861,050	867,891	874,241	976,690	1,031,302	1,011,958	860,545	952,119		



	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Units of dental activity contracted	312,427	624,854	833,138	728,997



	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from general practice	12,500	12,500	12,500	12,500
Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS 111	5,276	5,276	5,276	5,276

Data Quality – Issues around data quality in relation to appointments in primary care.

- Mitigations include work to improve data quality and data collection through the continued roll out of Edenbridge Apex in 2023/24. This currently covers 65% of practices. Edenbridge Apex is a tool that supports practices to evaluate changes in practice population trends, increases in healthcare demands and support quality improvement work focused around capacity, demand and unmet need.
- In addition, a clinical effectiveness scheme will be rolled out to support general practice to adopt standardised methods of clinical coding.

The ability to manage increasing demand and expectation around access without unintended consequences impacting upon on quality

- **Access and patient satisfaction:** despite appointment numbers increasing since 2019 patient demand continues to outstrip capacity, and patient satisfaction rates have reduced.
- A Quality Improvement programme is in place, focussing on practices across NEL with the greatest access challenges, providing diagnostic support and targeted interventions and coaching
- Using Clinical Effectiveness (CEG) data to monitor clinical outcomes and inform the type of appointments those with long term conditions are accessing to ensure this cohort are getting the right care at the right time by the most appropriate clinician. For some this may be that digital appointments are the best option, for others this will be face to face.
- Management of prevention activity, patient 'turnover' which is 30% which means prevention activity (such as calling patients for immunisation and screening) is harder to achieve.
- Through the fuller programme, focus upon new integrated pathways particularly around continuity of care for those patients in high prevalence groups with complex needs
- **Workforce capacity risk. PCNs are struggling to recruit and retain into ARRS roles (lack of suitably trained staff). There are also a number of GPs and nurses nearing the age of retirement.**
- Engagement and workforce planning with PCNs. Working with training hubs and academy regarding recruitment and retention initiatives and review supervision and education and training packages to make it an attractive place to work

Risk that the Community Pharmacy Consultation Service (CPCS) is not fully utilised, freeing up capacity in general practice

- The CPCS service is well established and embedded within NEL. 100% of practices are set up to refer and 93% are actively referring using Pharmacy Outcomes. The 7% that haven't been referring are being actively targeted to support them to engage with the service. There is also work being undertaken to expand the range of health conditions being treated by pharmacies, to help release further capacity in general practice.

Dentistry – Increase in UDAs

- Dental Funds/allocations
- Changes to contractual targets
- Increased need due to deterioration of oral health during pandemic
- Oral Health inequalities highlighted as a result of pandemic
- Commissioning Capacity following delegation

Mitigations

- Urgent Dental Care Hubs have been extended to March 2024 to ensure cover for patients in pain are seen asap.
- Procurement of new practices where loss of services have occurred and where highest needs have been identified.
- Stabilisation of patients that are unable to find a dentist and need treatment following urgent dental care.

Mental Health and Learning Disability

Metric	Compliance	2023/24 Q4 Trajectory	Commentary
Inappropriate Out of Area Placement Bed Days		0	• Compliant trajectory submitted • Zero bed days in 2023/24
Access to IAPT Services		14,244 (28.00%)	• Access rate growth but non-compliant trajectory submitted • Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures. • Speed of recruitment would make also full year compliance problematic.
Estimated Dementia Diagnosis rate		66.7%	• Compliant trajectory submitted • 66.7% across 2023/24
Women accessing Perinatal Mental Health services		2,803 (8.76%)	• Access rate growth but non-compliant trajectory submitted • Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures. • Speed of recruitment would make also full year compliance problematic.
Community access for adults with SMI		64,798	• Compliant trajectory submitted • 5% increase by the end of 2023/24
Access to CYP services		24,322 (52.25%)	• Access rate growth but non-compliant trajectory submitted • CYP Urgent Care expansion is not predicted to increase access • Some places need to expand duration of treatment to meet rising acuity. This will not increase access.
Learning disability healthchecks		7000	• Compliant trajectory achieving 75% of healthchecks in 23/25. • There are some variation in performance at place and practice level. These variations are tracked and actioned through primary care and place quality reports.
Learning disability inpatients		23 (ICB commissioned) 20 (NHSE commissioned)	• Compliant trajectory with no more than 30 inpatients. • A learning review is undertaken for all LD inpatients to understand how an admission could have been prevented.

Workforce position 2023-24 and governance

NEL Summary Providers SIP		SIP Growth	SIP Growth %	Baseline SIP	QT1 SIP	QT2 SIP	QT3 SIP	QT4 SIP	Current Vacancy	March '24 Vacancy
Workforce	Medical	134	2.60%	5185	4585	4610	4623	5319	5.90%	3.80%
	Nursing	1028	8.20%	12468	12603	12782	13394	13496	17.50%	10.60%
	Substantive Total	2633	6.40%	41080	40641	40945	42737	43714	11.70%	6.00%
	Bank and Agency	-2447	-33.30%	7339	5782	5437	5132	4893	N/A	N/A
	Total	187	0.40%	48420	46423	46382	47869	48606	N/A	N/A

ICS Provider Summary		2022-23	2023-24
Workforce	Permanent	41,080	43,714
	Bank	5,014	3,697
	Agency	2,326	1,196
	Total	48,420	48,606

Review of Planned Growth 2023-24 and intentions

Providers: Significant planned growth of substantive staff across all main staff groups and significant reductions in bank and agency to meet operational plan requirements. Contingent on low sickness rates returning to pre pandemic %ages and reductions in turnover ranges from 3% to 4% on sickness absence and 11% to 13% on turnover.

Key recruitment Plans:

- Recruitment Nursing plans are a 50/50 split mix of domestic and international recruitment considerable numbers international recruitment utilising Capital Nurse. Plans developed in each provider but reviewed at regional level and monitored for specific roles and input through regional international recruitment, AHP council and Nursing through Chief Nurses Group.

- Local pipeline of Clinical support staff through well-developed local recruitment plans supported by mayoral academy work across the sector, linking into partnerships with Local colleges and local authorities building anchor networks to upskill and employ local people in our services.

- Key element of our medium to long term strategy is to develop this further with a focus on addressing inequality which a range of routes into jobs for our local population including increasing apprenticeships.

Primary Care:

- There is planned growth of 6.9% (22.7 FTE) for General Practice Nurses from March 2023 baseline to Q4.
- Expand the GP fellowship scheme with an aim to ensure that fellowships are offered in all PCNs.
- Recruit to MDT roles under the Additional roles reimbursement scheme.
- Key recruitment programmes through PCNs and NEL training hub to support workforce planning and interventions.

Mental Health:

- CYP Access – maintain levels of resourcing. Investment into perinatal services in order to ensure LTP access target is reflected with an accompanying workforce increase. Recruitment and plan development overseen by our Mental Health Transformation Board.

Governance and Controls to manage growth and productivity

Working with providers to

- Theatre utilisation programme to increase productivity from 65% to 85%
- Proactive sickness absence management and improved rostering practices to deliver efficiencies
- Recruitment plans that aims to achieve high level substantive fill rates and reduce reliance on temporary staff
- Controls to review of long-term agency and bank staff in positions that could be filled substantively
- Move to a bank first approach with appropriate controls i.e *NELFT Staff Bank Development -drawing on guidance in NHSEI Staff Bank Development toolkit and a variety of improvement activities*
- Develop consistent temporary staffing rates and governance ensuring alignment with rates across NEL and London
- To use collaboratives to drive specialised rates and agreements in Acute and Mental Health
- Reduction in premium rates for medical staff
- Increased temporary staffing recruitment events to recruit more staff to banks and reduce our reliance on agencies

Primary Care:

- During 2023/24 ,to achieve 90% conversion of trainees within the system footprint. Ensure that PCN and GP employers have access to workforce planning tools and information in 2022/23

ICS:

- WF productivity Group to provide oversight of monitoring against the plan reviewing activity finance and workforce
- Strategic workforce developments through wider strategy development overseen by NEL People Board

Workforce - Key lines of enquiry and actions

- Workforce and cost increases need to be aligned during triangulation.
- Focus on testing workforce costs against activity and delivery.
- Validating the pay costs in cost improvement programmes to ensure that they are robust.
- Any investment requirement for additional workforce is clearly understood and identified.
- Assurance on delivery on substantive recruitment plans, through monitoring of supply bridge plans with focus on:
    - Recruitment plans to reduce vacancies focusing on premium rate agency areas
    - Ensuring measures are taken to ensure sickness rates return to pre covid levels
    - Retention initiatives to reduce turnover to ensure vacancies are reduced.
- Productivity and bank and agency to be reviewed regularly through WF productivity group, comprising finance, medical, operations and people leaders.

Finance: ICS 23/24 Plan Submission - Summary

- The ICS operating finance plan submitted on 4th May showed a movement from a system deficit to a system breakeven position.
- This represents a £73.1m improvement from the plan submitted on 30 March.
- Within the overall breakeven plan, Barts have a deficit, BHRUT and Homerton are close to breakeven and the ICB, ELFT and NELFT are all delivering a surplus to offset the deficit. The table below shows the movement from a system deficit to breakeven position.
- The ICB plans to deliver a £15.4m surplus.
- There are significant financial risks in the submitted system plan.

	ICS £m	ICB £m	BHRUT £m	Barts £m	ELFT £m	Homerton £m	NELFT £m
Plan Submission March - Surplus / (Deficit)	**(73.1)**	**0.0**	**(19.5)**	**(50.0)**	**0.0**	**(3.6)**	**0**
BHRUT stretch	9.0		9.0				
MH non-recurrent support	10.0				4.2		5.8
ICB measures	13.7	13.7					
Non-recurrent additional allocation	13.3		5.1	6.2		2.0	
NHSE support for excess inflation	11.3		3.0	7.7		0.6	
IFRS 16 revenue funding	0.8	0.1	0.0	0.1	0.1	0.2	0.2
Specialist Commissioning growth	5.4		0.8	4.3		0.3	
Stretch balance required for system breakeven	9.6	1.6	1.4	3.8	1.1	0.7	1.0
Total Plan Submission May - Surplus / (Deficit)	**0.0**	**15.4**	**(0.2)**	**(27.8)**	**5.4**	**0.2**	**7.0**

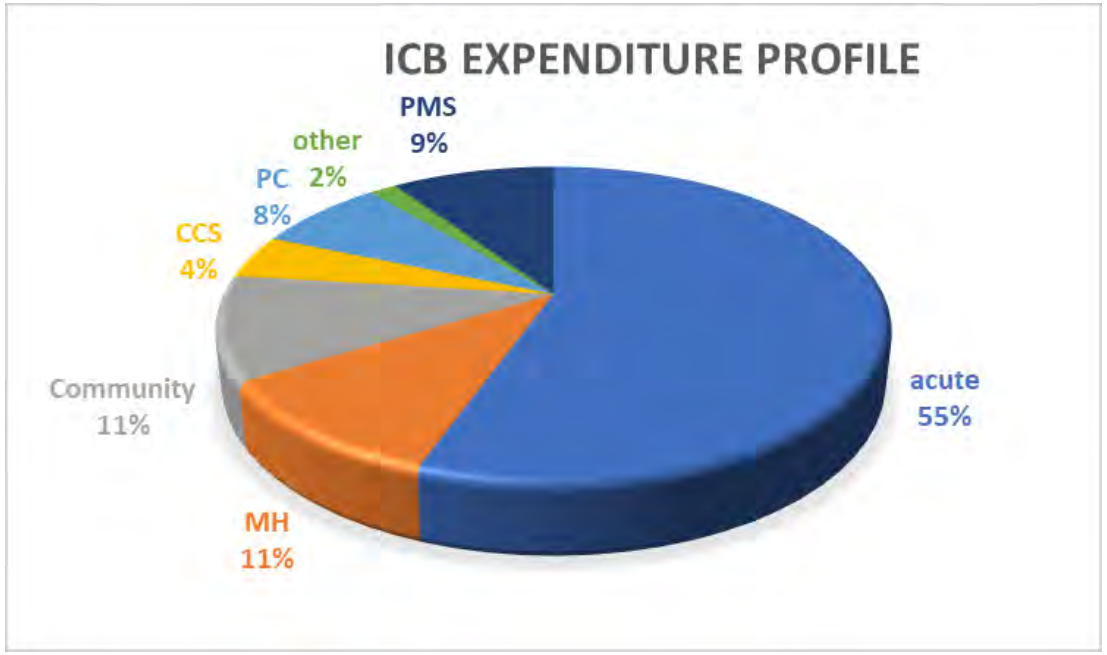
Finance: ICS 23/24 Plan Submission – Risks and Efficiencies

- The plan has required significant non-recurrent actions to close the gap. These non-recurrent actions create additional financial risk in future years (£98m)
- Efficiencies of £278m are required to balance the plan, of which £133m (49% total) are rated as high risk, with only £62m rated as fully developed (24% total).
- Potential risks with no identified mitigations of £209.5m have been identified.
- The main risks to delivery included in the plan are:
  - Delivering efficiencies
  - Managing risk
  - Run rate pressures, including inflation, agency usage and winter pressures
  - Delivery of ERF in plan at marginal costs, however, to deliver ERF in full may require additional costs and non-delivery puts £63m of ERF funding at risk
- Efficiencies and unmitigated risks by organisation are shown in the table below

	Efficiencies £m	Unmitigated Risk £m
BHRUT	(32.0)	(13.0)
Barts	(106.4)	(119.5)
ELFT	(20.8)	0.0
Homerton	(17.8)	(15.0)
NELFT	(18.2)	0.0
Provider Total	**(195.2)**	**(147.5)**
ICB	(82.6)	(62.0)
ICS TOTAL	**(277.8)**	**(209.5)**

Finance: ICB 23/24 Plan – Programme Detail

Plan Detail	Plan £m
Recurrent Allocation	4,042.5
Non-Recurrent Allocation	175.2
Total Allocation	**4,217.7**
Planned Expenditure	
Acute	(2,311.1)
Mental Health	(448.9)
Community Health Services	(444.5)
Continuing Healthcare (CHC)	(186.4)
Primary Care and Prescribing	(314.5)
Delegated Primary Care	(392.9)
Other Programme Services	(22.4)
Other Commissioned Services	(43.0)
Running Costs	(38.7)
Total Expenditure	**(4,202.3)**
Planned Surplus / (Deficit)	**15.4**



- MH : mental health
- CCS: Continuing care services
- PC: primary care
- PMS: Primary medical services
- Other: programme services
- Other : commissioned services

- The plan detail shows the split of programme and running cost expenditure. All areas have had the operating planning technical assumptions factored in and efficiency targets have been included in the relevant programme areas.
- The recurrent ICB allocation is £4,042.5m. Additionally, non-recurrent allocations have been received of £175.2m giving a total 23/24 allocation of £4,217.7m.
- Expenditure plans of £4,202.3m have been submitted in the plan which gives a planned surplus of £15.4m in 23/24.

Finance: ICB 23/24 Plan Submission - Summary

	March - Submission 1 £m	April - Submission 2 £m	May - Submission 3 £m
ICB Surplus / (Deficit)	**(18.5)**	**0.0**	**15.4**
ICB Efficiencies (recurrent and non-recurrent)	(62.2)	(80.8)	(82.6)
ICB Risks	(48.0)	(56.6)	(62.0)

- The ICB has submitted the operating plan in line with national deadlines. This has shown a movement in the plan from a starting deficit of £18.5m to a final planned surplus of £15.4m.
- The ICB has followed national guidance when developing the plan – planning guidance and uplifts have been applied, delegated primary care funded and it is assumed that the mental health investment standard will be met.
- The movement from a planned deficit of £18.5m to a planned surplus of £15.4m has meant that the level of planned efficiencies has increased. In the final version of the plan it is expected that the ICB will deliver £82.6m of efficiencies, of which £31m is recurrent and £51.6m is non-recurrent.
- Whilst the level of efficiency in relation to the overall ICB allocation is circa 2% in reality the ICBs are not able to influence all areas of spend. This means that delivery of efficiencies in 23/24 will be extremely challenging and represents an efficiency ask in the region of 8% to 10%.
- As part of the planning process the ICB has had to review all planned investments and SDF funding and has assumed some slippage, delays and use of SDF to support baseline expenditure. In total this equates to £14m.
- There is a high level of risk built into the ICB financial plan, which if they materialise, will negatively impact the ICBs ability to deliver a surplus position.
- The main risks flagged in the ICB in relation to delivery of efficiencies and further price and activity increases in CHC and prescribing. As the levels of efficiency delivery have increases so has the level of financial risk.
- Whilst the ICB is planning to deliver a surplus in 23/24, this will only be possible with the delivery of non-recurrent efficiencies. Therefore, the recurrent underlying position of the ICB is a deficit of £49m.

Finance: ICB 23/24 Plan – Efficiencies and Risk

Area of Expenditure	Scheme	Recurrent £m	Non Recurrent £m	Total £m	Risk Rating	Efficiency Risk / Mitigations £m	Other Risks / Mitigations £m	Total Risk / Mitigations £m
Continuing Care	CHC	(11.0)	(4.0)	(15.0)	High	(8.5)	(6.6)	(15.1)
Prescribing	Prescribing	(5.1)	(12.0)	(17.1)	High	(11.5)	(6.6)	(18.1)
NHS Property Services	Property Services	(1.1)		(1.1)	Medium	(0.5)		(0.5)
Non Recurrent Programmes	Non Recurrent Benefits		(27.0)	(27.0)	High	(13.5)		(13.5)
Programme Projects	Programme corporate	(6.0)		(6.0)	High	(4.5)		(4.5)
Running Costs	Running Costs (5%)	(1.9)		(1.9)	Medium	(1.0)		(1.0)
Programme Projects	Agency Control (Q2)	(3.0)		(3.0)	Medium	(1.9)		(1.9)
Programme Projects	Consultancy Spend		(1.0)	(1.0)	Medium	(0.3)		(0.3)
Programme Projects	Recruitment delay		(6.0)	(6.0)	Medium	(4.5)		(4.5)
Acute Reserves	Repatriation/ERF (Acute)	(3.0)		(3.0)	Medium	(1.5)		(1.5)
Non Recurrent Programmes	Unidentified risk		(1.6)	(1.6)	High	(1.2)		(1.2)
Non Recurrent Programmes	Unidentified mitigation					48.8	13.1	62.0
TOTAL		**(31.0)**	**(51.6)**	**(82.6)**		**0.0**	**0.0**	**0.0**

- The table details the efficiencies required to deliver the surplus position. It is expected that £31m will be delivered recurrently and £51.6m delivered non-recurrently.
- £1.6m of efficiencies are yet to be identified. This relates to the additional stretch added to the ICB position in order for the system planned break-even position to be achieved.
- Delivery of efficiencies is a risk to the ICB and they have been risk assessed as either high, medium or low risk. This has resulted in a risk to delivery of £48.8m. Other risks of £13.1m have been flagged in relation to price and activity increases in CHC and prescribing. The total risk is £62m. It is assumed that the ICB will mitigate the risk but these mitigations are yet to be identified. If any of the risks identified materialise this will impact on the ICBs ability to deliver a £15.4m surplus.

Finance: ICB 23/24 Plan – Investment and SDF

Investment Category	Net Total Investment £m
Health Inequalities Fund	3.6
Other Health Inequalities schemes	0.9
IVF	1.0
Other improved outcomes in population health and health care schemes	2.1
REACH - Barts and BHRUT	2.8
GP Enhanced Access NEL	4.0
Other Productivity and Value for Money Schemes	1.6
Social and economic development schemes	0.8
Sub-Total	**16.7**
Additional Pressures and Mitigations	
Revenue implications of capital expenditure	0.8
Full year effect of prior year business cases	1.6
Acute associates pressure	2.0
Mitigations to offset pressures	(5.3)
Total Additional Pressures / Mitigations	**(0.9)**
TOTAL	**15.8**

SDF Programme	Revised Allocation £m
Ageing Well	2.3
Alcohol	0.3
Cancer	10.6
CVD	0.1
CYP	0.6
Diabetes	0.5
LD & Autism	3.4
Long Covid	2.3
Maternity	1.6
Mental Health	39.4
Other	0.1
People	0.1
Primary Care	6.2
Pulmonary Rehab	0.5
Tobacco	1.6
TOTAL	**69.5**

- The ICB measures of £13.7m that formed part of the movement to a surplus position relate to the delay of investments and using SDF funding for baseline services and a contribution towards programme costs.
- The tables above show the total investment and SDF included in the operating plan.
- This shows that there is £15.8m planned investments and £69.5m SDF.

Finance: ICB 23/24 Plan – Underlying Position

	Plan £m
Recurrent Allocation	4,042.5
Planned Recurrent Expenditure	(4,091.7)
Underlying Surplus / (Deficit)	**(49.2)**

- Allocation and expenditure plans have been submitted which gives a planned surplus of £15.4m in 23/24.
- However, the underlying run-rate for the ICB at the end of 23/24 is a deficit. Once non-recurrent efficiencies and spend against non-recurrent allocations have been removed from the 23/24 planned total expenditure this gives a recurrent expenditure level of £4,091.7m. As the recurrent allocation is £4,042.5m this gives a recurrent deficit of £49.2m.
- Materialisation of the risks flagged or non-delivery of the recurrent efficiencies may impact on this further.

Finance: Capital 2023/24 and 2024/25

- The ICS capital plan submitted was compliant with the system CDEL allocation

	2023/24 £'m	2024/25 £'m
Core CDEL	79.104	78.405
Bonus	8.054	0.000
Total capital allocation	**87.158**	**78.405**
5% over programming	4.358	3.920
Total charge against capital allocation	**91.516**	**82.325**

- The NEL allocation for 23/24 is £91.5m, of which £79m is core allocation, £8m reward for meeting 2022/23 revenue target as a system and includes an allowance of 5% over programming (£4.3m).
- It was also required to declare a plan for 24/25, aligned with core CDEL and 5% over programming
- It should be noted that 5% over programming was included in the 22/23 plan and subsequently was not available
- The guidance on capital indicates that over spends against CDEL allocation would be clawed back by a reduction in allocation in the following year. NEL 2022/23 outturn was an over spend against CDEL allocation of £12.4m.
- However, expenditure on St. Georges was funded centrally (£5.2m) and not from STP wave 4b funds and a late allocation of diagnostics (£2m) reduced the overspend to £5.2m. The London wide position, however, is essentially balanced and we appear to have avoided suffering any reductions in 23/24. This overspend against CDEL required delaying both costs and projects into 23/24, to the value of c.£11m, adding further pressure onto already overcommitted available
- By a number of measures it can be demonstrated that NEL is underfunded in capital, due in part to the nature of the national allocation formula, having two large PFI builds and historic under investments (perpetuated by a formula that is based on existing asset valuations (not land) and depreciation).
- London are working with us to make our case to national with regards the disadvantages of the current methodology for NEL (estimated at c.£20-30m annually) , to request for these to be taking into account in future years and help in 2023/24 to meet our essential requirements.
- Estimates for 23/24 indicate NEL CDEL needs to be of the order of £170m
- If investments in 23/24 are limited to just work in progress, deferred costs , legal obligations and match funding :

	£'m
Year end 22/23 costs deferred into 23/24	11.0
Match fund essential EPR work at BHRUT	11.0
Remedial fire works Newham	17.0
Completion of HUH ITU build	8.0
St Georges	7.0
Costs in excess TIF funds	6.0
National program slippage	10.0
Projects already under construction	10.0
Contractual commitments	11.0
Total	**91.0**

- This does not address any routine essential repairs or replacement programs and certainly no funds for emergency replacements or arising regulatory compliance issues or IT investment, which is particularly problematic.
- There are further sources of CDEL that will be available to NEL in 23/24 & 24/25. these relate to specific funding pots are were available to other ICS's as well:

	2023/24 £'m	2024/25 £'m
TIF	40.1	3.9
Frontline digitisation- inc. 50% BHRUT EPR	12.1	11.2
UEC Additional Capacity	7.1	0.0
St Georges (STP wave 4b)	17.0	0.0
CDC	8.0	0.0
Diagnostic digital capacity	16.7	11.0
Total additional CDEL awards	**101.0**	**26.1**

- Note, funding for Whipps Cross rebuild has also been earmarked but the program has currently stalled. We wait for approval to progress.
- Our next step completion of detailed 3 year evidenced, risk assessed and costed plan to understand the full nature of the shortfall and the impact potentially on our ability to deliver patient care.

Executive Summary / Summary of Key Issues:	Purpose of Paper / Ask of the Board:
The slide outlines the finance dashboard of the Waltham Forest H&C Partnership The suite of slides have been refreshed with latest available data with the following updates: **I&I / Health Inequalities –** outline of YTD and projected spend for both funding streams. **Centre of Excellence -** Year 2 implementation plan is identified for scale up. Further development, roll out of pathways for new ways of working and further recruitment to clinical roles planned. It is anticipated that Year 2 spend will be as predicted but will be dependent on the successful recruitment of clinical staff.	The Waltham Forest Health and Care partnership Board is asked to: • To note the attached Finance update for the Waltham Forest H&C Partnership.
Engagement:	**Specific Risks:**
• Report done in collaboration with scheme leads	In all areas there remain risks around the ability to successfully recruit. We are working closely with leads o mitigate the risk wherever possible.

I&I Fund: Budget position Month 2

Project	Agreed Planned £'000	22/23 Actual	Actual Spend YTD		Projected spend 23/24				Project spend 23/24 year end	Committed Projected carry forward 24/25	Total
			Apr-23	May-23	Q1 end	Q2	Q3	Q4			
Barts	£842	£63	£33	£34	£79	£208	£208	£155	£780	£62	**£842**
NELFT	£1,276	£29	£44	£53	£159	£310	£310	£298	£1,203	£73	**£1,276**
NEL ICB	£144	£34	£0	£0	£9	£26	£26	£26	£121	£23	**£144**
LA	£1,878	£342	£20	£190	£167	£471	£273	£432	£1,895	-£17	**£1,878**
Other	£6		£0	£0		£2	£2	£2	£6	£0	**£6**
Total Committed	**£4,146**	**£468**	**£97**	**£277**	**£414**	**£1,017**	**£819**	**£913**	**£4,005**	**£141**	**£4,146**
System pressures contingency	£1,462								£1,462		**£1,462**
Total Budget	**£5,608**								**£5,467**	**£141**	**£5,608**

- Current projected spend up to year end 23/24 is £4m with £141k remaining committed to carry forward to 24/25
- Actual spend for Apr and May is £374k which includes all billing from Barts, NELFT and actual spend on LA SAP system
- This gives **remainder in budget of £1,462m** which will be used as contingency funding to support system pressures
- The system pressure areas under consideration include Integrated Equipment budget and Clinical Leadership for Partnership transformation programmes

Health Inequalities Fund 22/23: budget position

Project Code	Scheme	Budget allocation £'000	Actual spend 22/23	Starting position 23/24	Actual Spend 23/24		Projected Spend for 23/24				Total fund spend	Carry forward position	Provider
					Apr	May	Q1	Q2	Q3	Q4			
HIPA001	Healthy Weight Programme	160	160	-			-				160	-	BeeZee Bodies
HIPA002	Personalised Care Plans LTC catch up	250	250								250	-	GP Federation Network
HIPA003	Community Health Literacy Improvement	50		50		6	12	11	11	10	50	-	VSCE Org (TBC)
HIPA004	Social Prescribing Community Chest	40	-	40		17	23				40	-	LBWF (Social Prescribing
HIPB005	Fuel Poverty	155	90	65			65				155	-	HEET
HIPB006	Health checks / POCT	157	-	157				52	52	53	157	-	Public Health / GP FedNet
HIPB007	LD Vaccinations	79	-	79				20	20	20	60	19	NELFT
		891	500	391	-	23	100	83	83	83	872	19	

- Starting position for 23/24 is £391k with actual spend in 22/23 of £500k
- Budget depleted for Health Weight Programme – plan to continue funding for 23/24 and 24/25
- Personalised Care Plans – payment accrued in 22/23 and reimbursement invoice paid to ICB. Monthly monitoring on billed evidence is being undertaken to reconcile against this payment in 22/23
- Budgets will be fully spent by Q2 for Fuel Poverty and Social Prescribing Community Chest continued funding for 23/24
- No spend to date on Health Checks / POCT – a revised proposal for this budget is currently in development and will be brought back to I&I and HI Funds Oversight Group by 23 June for final review.
- LD Vaccinations has not yet started recruitment and so projecting spend to start in Q2. With commitment to a 12 month contract this will mean a carry forward of £19k to Q1 in 24/25

Appendix 1

INNOVATION & INVESTMENT FUND – ACTUAL AND PROJECTED SPEND AGAINST EACH SCHEME

Key:	
	Reported on SAP system
	Reported as billing from provider
	Spent and invoiced from ICB
	Fund depleted

Project Code	Scheme	Costs	22/23 Actual	Apr-23	May-23	Projected Q1 Finish	Projected Q2	Projected Q3	Projected Q4	Spend by 23/24 year end	Committed carry forward 24/25	Provider
IIF001	Hospital at Home	292,960	17,417	9,366	7,617	35,548	73,241	73,241	73,241	**289,671**	3,289	Barts Health
IIF002	VCSE Involvement in Partnership	103,819				25,955	25,955	25,955	25,954	**103,819**	0	LA (MIND CHWF)
IIF003a	Transformation post (Mental Health)	54,832	13,519	4,606	4,606	4,605	13,817	13,817	13,817	**68,785**	- 13,953	LA
IIF003b	Transformation capacity (C&YP)	67,653	17,706	6,034	6,034	6,034	18,102	18,102	18,102	**90,112**	- 22,459	LA
IIF003c	Transformation post (Promoting Well Being)	54,832	11,587			13,817	13,817	13,817	13,817	**66,853**	- 12,021	LA
IIF004a	Project Management: I&I Oversight	141,341	65,399		8,700	15,865	24,566	24,566	-	**139,097**	2,244	LA
IIF004b	Project Management: Social Care Reform	141,341	93,849	4,813	13,837	4,813	23,463	-	-	**140,775**	566	LA
IIF004c	Project Management: Home Care model	80,000	80,000			-				**80,000**	-	LA
IIF006	Community SALT Waiting lists and Backlogs	158,861	23,646	12,439	10,306	8,595	37,515	37,515	21,865	**151,881**	6,980	Barts Health
IIF008	LD employment offer in WF	175,000			395	23,356	41,249	41,249	51,249	**157,498**	17,502	LA
IIF009	Reducing waiting lists for the adult ASD pathway	212,709		9,507	9,507	34,161	53,175	53,175	53,175	**212,700**	9	NELFT
IIF010	Waiting lists adult ADHD pathway	514,025		16,981	23,030	88,495	128,506	128,506	128,506	**514,025**	0	NELFT
IIF012	Developing Home Response Service	250,000			118,000	-				**118,000**	132,000	LA
IIF013	Community Advocacy and LPS implementation	14,115	14,115			-				**14,115**	-	LA
IIF017.1	Promoting Wellbeing (Age UK)	33,076	33,076			-				**33,076**	-	NEL ICB
IIF017.2	Telecare & Technology enabled care contract	65,848	15,940	4,194	1,798	12,583	28,761	2,396		**65,672**	176	LA
IIF018	Autistic Children Pre and post-diagnostic (NELFT)	48,457				-	12,114	12,114	12,114	**36,343**	12,114	NELFT
IIF018	Autistic Children Pre and post-diagnostic (LA)	125,000			420	20,205	31,251	31,251	31,251	**114,378**	10,622	LA
IIF019	Paediatric Physio First	90,000				7,500	22,500	22,500	22,500	**75,000**	15,000	Barts Health
IIF021	CYP Mental Health	347,543				-	173,772		173,772	**347,544**	- 1	LA / VCSE
IIF022	SEND Service Capacity	226,000			35,888	39,354	77,203	33,073	8,369	**193,887**	32,113	LA
IIF029	CYP Urgent & Emergency Care	95,000	-			7,917	23,750	23,750	23,750	**79,167**	15,833	Barts Health
IIF030	Homeless Health in WF	78,555				-	19,639	19,639	19,639	**58,917**	19,638	NEL ICB
IIF031	CHC Standardisation	30,300	30,300			-				**30,300**	-	LA
IIF032	Spirometry Waiting List Reduction	34,502	17,251	2,656	2,656	11,940				**34,503**	- 1	NELFT
IIF033	Tracheostomy Pathway	72,907	12,151	6,076	6,076	6,076	18,228	18,228	6,076	**72,911**	- 4	NELFT
IIF034	Children's Community Dietetic Service	74,084	2,280	5,032	5,295	8,194	18,521	18,521	16,241	**74,084**	0	Barts Health
IIF035	Musculoskeletal (MSK) Physiotherapy	131,809	19,469	6,537	10,772	11,525	32,952	32,952	15,701	**129,907**	1,902	Barts Health
IIF036	Reducing Childrens OT	264,603		7,269	7,269	7,269	66,151	66,151	66,150	**220,259**	44,345	NELFT
IIF037	CYP Specialist Continuing Care Nurse	29,163			2,430	2,430	7,290	7,290	7,290	**26,730**	2,433	NELFT
IIF038	CYP Complex Continence Advisory Service	99,474		1,823	1,823	8,290	24,870	24,870	24,870	**86,546**	12,928	NELFT
IIF039	Partnership Development	628	628			-				**628**	-	Other
IIF039.1	PCN involvement in Partnership	6,000				-	2,000	2,000	2,000	**6,000**	-	Other
IIF040	Comms & Engagment	30,000	1,711			6,050	7,413	7,413	7,413	**30,000**	-	NEL ICB
IIF041	End of Life Engagement	2,625				2,625				**2,625**	-	NEL ICB
		4,147,062	**470,043**	**97,332**	**276,459**	**413,202**	**1,019,820**	**752,089**	**836,860**	**3,865,806**	**281,256**	

Community Model of Care 22/23: budget position

No.	Project	Agreed Planned Amount	22/23 Actual Spend	23/24 Opening Position	M02 Actual Spend	23/24 FOT	22/24 FOT Total	24/25 Carry forward	Provider
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1	CC2H/Home First/CoE	£4,945	£789	£4,156	£225	£2,839	£3,628	£1,317	Various
2	Implementation Capacity	£1,870	£550	£1,319	£122	£730	£1,281	£589	NEL ICB
3	Children's transformation	£412	£0	£412	£0	£0	£0	£412	NELFT
4	Children's contingency	£306	£0	£306	£0	£0	£0	£306	NELFT
	Total	**£7,533**	**£1,340**	**£6,193**	**£346**	**£3,569**	**£4,909**	**£2,624**	

- Starting position for 23/24 is £6,193k with actual spend in 22/23 of £1,340k
- Year 1 was identified for consolidation, the recruitment of the delivery team, development of some pathways and the initial recruitment to clinical roles. Year 2 for scaling up, further development of pathways with Year 3 for full roll out and implementation
- Due to the pandemic, the pre-implementation phase was delayed, and the recruitment of the delivery programme team took place later than the expected, with the full team being recruited in February 2023.
- Recruitment into the clinical roles by providers also resulted in delays due to recruitment processes, notice periods and some roles being hard to recruit to. Approximately, 50% of Year 1 clinical roles were in place in January 2023. Therefore, there has delay in the delivery of the implementation plan for Year 1 which in turn means that actual spend has been significantly lower than the predicted spend for Year 1. It has been agreed that the underspend for Year 1 be carried over into Year 2.
- Year 2 is identified for scale up, further development, roll out of pathways for new ways of working and further recruitment to clinical roles. It is anticipated that Year 2 spend will be as predicted but will be dependent on the successful recruitment of clinical staff.

Executive Summary / Summary of Key Issues:

This paper presents the HCPB with the planned schemes and budget allocations for the Health Inequalities Fund 2023-2026.

- Funding allocated for WF Health & Care Partnership **£771k** per annum and totals **£2.3m** over 3 year period.
- Planning for distribution of this fund has been overseen through the Innovation & Investment and Health Inequalities Oversight Group who have considered:
  - Continuation of schemes run in 22/23 providing funding for further 12 -24 months to fully develop projects that have started to demonstrate impacts in tackling health inequalities
  - Development of new schemes which align with priorities that facilitate new and transformational ways which focus on prevention, reducing health inequalities and support the delivery of agreed Partnership actions in response to the Marmot Review (A healthier and Fairer Waltham Forest
- The proposal is to further develop local community resilience with funding support available for 24/25 and 25/26, with meaningful engagement for an integrated approach in designing projects with community and voluntary groups.
- Agreement with NEL ICB contracts team to extend the current section 256 agreement between NEL ICB and LB Waltham Forest to include the funding allocation for 23 - 26.
- Contracting arrangements are identified for majority of schemes which will be with service providers / voluntary services and ICB / LB Waltham Forest (details for each scheme included on following slide).
- The WF contribution for Pre-paid Prescriptions for Care Leavers to be allocated within the S256 agreement and monitored through the WF Place arrangements outlined below
- The Health Inequalities Fund for Waltham Forest Health & Care Partnership will be overseen by the Innovation & Investment and Health Inequalities Funds Oversight Group who report to Waltham Forest Finance Oversight Group providing monthly updates on progress and spend.

Purpose of Paper / Ask of the Board:

The Board is asked to:

- Approve the recommended schemes and funding allocations for 23/24 and for those schemes with continued funding for 24/25 and 25/26.
- Agree the proposal for funding to be held within S256 agreement between NEL ICB and LB Waltham Forest.
- Agree the strategic approach to support further development of local community resilience through Health Inequalities funding for 24/25 and 25/26.

Engagement:

- Engagement with system partners in Waltham Forest to date has indicated a strong desire for Waltham Forest Health & Care Partnership to prioritise the Health Inequalities fund over next 3 years on programmes of work that facilitates new and transformational ways which focus on prevention and reduce health inequalities and support the delivery of agreed Partnership actions in response to the Marmot Review.
- Each scheme has undertaken engagement with their own specific system stakeholders, voluntary and community groups and residents.

Specific Risks:

- Delays in recruitment and mobilising of schemes which cause slippage in spend – MOUs / contracts for each scheme will be in place to support providers in starting recruitment process as early as possible
- Lack of clear evidence on actual spend and activity against schemes to provide assurance on payments made – a clear process on billing and activity reporting is established and will be undertake by new schemes for 23/24 for monthly reporting to I&I and HI Oversight Group and WF Finance Group

Health Inequalities Fund 2023/26

- Planning for distribution of Health Inequalities Fund for 23-26, put forward by Innovation & Investment and Health Inequalities Oversight Group is as follows:

Scheme	23/24 Agreed Planned Amount £'00	24/25 Agreed Planned Amount £'00	25/26 Agreed Planned Amount £'00	Total 23-26	Contract arrangements
Children's Weight Management	£160,000	£160,000		£320,000	BeeZee contracted through WF Public Health
Fuel Poverty	£90,000			£90,000	HEET contracted through LB Waltham Forest
LTCs access to employment	£95,000	£95,000	£95,000	£285,000	Employment Business and Skills (EBS) LB Waltham Forest
Homeless Health Service	£136,230	£136,230	£136,230	£408,690	NELFT contracted through ICB
Embedding Marmot	£50,000			£50,000	Kings Fund (in partnership with) contracted through LB Waltham Forest
Integrated Locality LTC model	£194,000	£194,000	£194,000	£582,000	TBC
Community Chest	£40,000	£40,000		£80,000	LBWF Social Prescribing Team awards made to Volutnary services and community groups
Prepaid Prescriptions for Care Leavers	£6,000	£6,000	£6,000	£18,000	Included in S256 agreement between ICB and LA and monitored through WF H&C Partnership's existing arrangements of I&I and HI Funds Oversight Group
Total Planned	**£771,230**	**£631,230**	**£431,230**	**£1,833,690**	
24/25 & 25/26 unplanned	£0	£140,000	£340,000	£480,000	
Total allocation WF H&C Partnership (over 3 years)	**£771,230**	**£771,230**	**£771,230**	**£2,313,690**	

- Schemes continued from 22/23 are Children's Weight Management, Fuel Poverty and Social Prescribing Community Chest.
- Pre-paid Prescriptions for Care Leavers is a NEL ICB scheme with contributions from each place. The Waltham Forest Care Leavers cohort have been identified for support through the Council Care Leavers service.
- Plans have now been developed for 6 of the schemes and work on the Integrated Locality LTC model is underway.
- The developed plans are also linking in with existing individual local governance arrangements for delivery and monitoring on schemes.